

A NONSUBSTANTIVE REVISION
OF STATUTES RELATING TO
SOLVENCY OF INSURERS, PROPERTY AND CASUALTY
INSURANCE, OTHER TYPES OF INSURANCE COVERAGE,
AND UTILIZATION REVIEW AND INDEPENDENT REVIEW

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deposit of greater or greatest amount and value and to permit the new or surviving reinsuring company, upon proper showing that there is such duplication of deposits and that the new or surviving company is the owner thereof, to withdraw any or all duplicate or excessive deposits.

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10 SUBCHAPTER A. GENERAL PROVISIONS
11 Revised Law
12 Sec. 4201.001. PURPOSE. The purpose of this chapter is to:
13 (1) promote the delivery of quality health care in a
14 cost-effective manner;
15 (2) ensure that a utilization review agent adheres to
16 reasonable standards for conducting utilization review;
17 (3) foster greater coordination and cooperation
18 between a health care provider and utilization review agent;
19 (4) improve communications and knowledge of benefits
20 among all parties concerned before an expense is incurred; and
21 (5) ensure that a utilization review agent maintains
22 the confidentiality of medical records in accordance with
23 applicable law. (V.T.I.C. Art. 21.58A, Sec. 1.)
24 Source Law
25 Art. 21.58A
26 Sec. 1. The purpose of this article is to:
27 (1) promote the delivery of quality health
28 care in a cost-effective manner;
29 (2) assure that utilization review agents
30 adhere to reasonable standards for conducting
31 utilization reviews;
32 (3) foster greater coordination and
33 cooperation between health care providers and
34 utilization review agents;
35 (4) improve communications and knowledge
36 of benefits among all parties concerned before
37 expenses are incurred; and
38 (5) ensure that utilization review agents
39 maintain the confidentiality of medical records in
40 accordance with applicable law.

1 otherwise lawfully providing health care services; and

2 (B) eligible for independent reimbursement for
3 those health care services.

4 (6) "Health insurance policy" means an insurance
5 policy, including a policy written by a corporation subject to
6 Chapter 842, that provides coverage for medical or surgical
7 expenses incurred as a result of accident or sickness.

8 (7) "Life-threatening" means a disease or condition
9 from which the likelihood of death is probable unless the course of
10 the disease or condition is interrupted.

11 (8) "Nurse" means a professional or registered nurse,
12 a licensed vocational nurse, or a licensed practical nurse.

13 (9) "Patient" means the enrollee or an eligible
14 dependent of the enrollee under a health benefit plan or health
15 insurance policy.

16 (10) "Payor" means:

17 (A) an insurer that writes health insurance
18 policies;

19 (B) a preferred provider organization, health
20 maintenance organization, or self-insurance plan; or

21 (C) any other person or entity that provides,
22 offers to provide, or administers hospital, outpatient, medical, or
23 other health benefits to a person treated by a health care provider
24 in this state under a policy, plan, or contract.

25 (11) "Physician" means a licensed doctor of medicine
26 or a doctor of osteopathy.

27 (12) "Provider of record" means the physician or other
28 health care provider with primary responsibility for the care,
29 treatment, and services provided to an enrollee. The term includes
30 a health care facility if treatment is provided on an inpatient or
31 outpatient basis.

32 (13) "Utilization review" means a system for
33 prospective or concurrent review of the medical necessity and
34 appropriateness of health care services being provided or proposed

1 to be provided to an individual in this state. The term does not
2 include a review in response to an elective request for
3 clarification of coverage.

4 (14) "Utilization review agent" means an entity that
5 conducts utilization review for:

6 (A) an employer with employees in this state who
7 are covered under a health benefit plan or health insurance policy;

8 (B) a payor; or

9 (C) an administrator holding a certificate of
10 authority under Chapter 4151.

11 (15) "Utilization review plan" means the screening
12 criteria and utilization review procedures of a utilization review
13 agent.

14 (16) "Working day" means a weekday that is not a legal
15 holiday. (V.T.I.C. Art. 21.58A, Sec. 2 (part).)

16 Source Law

17 Sec. 2. In this article:

18 . . .
19 (2) "Administrator" means a person holding
20 a certificate of authority under Article 21.07-6 of
21 this code.

22 (3) "Adverse determination" means a
23 determination by a utilization review agent that the
24 health care services furnished or proposed to be
25 furnished to a patient are not medically necessary.

26 . . .
27 (6) "Emergency care" means health care
28 services provided in a hospital emergency facility or
29 comparable facility to evaluate and stabilize medical
30 conditions of a recent onset and severity, including
31 but not limited to severe pain, that would lead a
32 prudent layperson possessing an average knowledge of
33 medicine and health to believe that his or her
34 condition, sickness, or injury is of such a nature that
35 failure to get immediate medical care could result in:

36 (A) placing the patient's health in
37 serious jeopardy;

38 (B) serious impairment to bodily
39 functions;

40 (C) serious dysfunction of any bodily
41 organ or part;

42 (D) serious disfigurement; or

43 (E) in the case of a pregnant woman,
44 serious jeopardy to the health of the fetus.

45 . . .
46 (8) "Enrollee" means a person covered by a
47 health insurance policy or plan and includes a person
48 who is covered as an eligible dependent of another
49 person.

50 (9) "Health benefit plan" means a plan of
51 benefits that defines the coverage provisions for

1 health care for enrollees offered or provided by any
2 organization, public or private, other than health
3 insurance.

4 (10) "Health care provider" means any
5 person, corporation, facility, or institution
6 licensed by a state to provide or otherwise lawfully
7 providing health care services that is eligible for
8 independent reimbursement for those services.

9 (11) "Health insurance policy" means an
10 insurance policy, including a policy written by a
11 company subject to Chapter 20 of this code, that
12 provides coverage for medical or surgical expenses
13 incurred as a result of accident or sickness.

14 (12) "Life threatening" means a disease or
15 condition for which the likelihood of death is
16 probable unless the course of the disease or condition
17 is interrupted.

18 (13) "Nurse" means a professional or
19 registered nurse, a licensed vocational nurse, or a
20 licensed practical nurse.

21 . . .
22 (16) "Patient" means the enrollee or an
23 eligible dependent of the enrollee under a health
24 benefit plan or health insurance plan.

25 (17) "Payor" means:

26 (A) an insurer writing health
27 insurance policies;

28 (B) any preferred provider
29 organization, health maintenance organization,
30 self-insurance plan; or

31 (C) any other person or entity which
32 provides, offers to provide, or administers hospital,
33 outpatient, medical, or other health benefits to
34 persons treated by a health care provider in this state
35 pursuant to any policy, plan, or contract.

36 (18) "Physician" means a licensed doctor
37 of medicine or a doctor of osteopathy.

38 (19) "Provider of record" means the
39 physician or other health care provider that has
40 primary responsibility for the care, treatment, and
41 services rendered to the enrollee and includes any
42 health care facility when treatment is rendered on an
43 inpatient or outpatient basis.

44 (20) "Utilization review" means a system
45 for prospective or concurrent review of the medical
46 necessity and appropriateness of health care services
47 being provided or proposed to be provided to an
48 individual within this state. Utilization review
49 shall not include elective requests for clarification
50 of coverage.

51 (21) "Utilization review agent" means an
52 entity that conducts utilization review for:

53 (A) an employer with employees in
54 this state who are covered under a health benefit plan
55 or health insurance policy;

56 (B) a payor; or

57 (C) an administrator.

58 (22) "Utilization review plan" means the
59 screening criteria and utilization review procedures
60 of a utilization review agent.

61 (23) "Working day" means a weekday,
62 excluding a legal holiday.

63 Revisor's Note

64 (1) Section 2(1), V.T.I.C. Article 21.58A,
65 defines "administrative procedure act." The revised

1 law omits the definition as unnecessary and
2 substitutes a reference to Chapter 2001, Government
3 Code, which is the Administrative Procedure Act, for
4 references to the "administrative procedure act"
5 throughout this chapter. The omitted law reads:

6 (1) "Administrative procedure
7 act" means Chapter 2001, Government Code.

8 (2) Section 2(2), V.T.I.C. Article 21.58A,
9 defines "administrator." The revised law incorporates
10 the substance of the definition of "administrator"
11 into the definition of "utilization review agent"
12 provided by Section 2(21), V.T.I.C. Article 21.58A,
13 revised in this chapter as Section 4201.002(14),
14 because that is the only other use of the term
15 "administrator" in V.T.I.C. Article 21.58A, revised as
16 this chapter. In addition, the definition of
17 "administrator" in Section 2(2) includes a reference
18 to "a certificate of authority under Article 21.07-6."
19 V.T.I.C. Article 21.07-6 is revised in various
20 chapters in this code. The relevant provisions are
21 revised in Chapter 4151 of this code, and the revised
22 law is drafted accordingly.

23 (3) Section 2(4), V.T.I.C. Article 21.58A, in
24 part defines "certificate" for purposes of Article
25 21.58A to mean a certificate of registration. The
26 revised law omits the provision as unnecessary and
27 substitutes a reference to a "certificate of
28 registration" for references to a "certificate"
29 throughout this chapter. The omitted law reads:

30 (4) "Certificate" means a
31 certificate of registration

32 (4) Section 2(5), V.T.I.C. Article 21.58A,
33 defines "commissioner" to mean the commissioner of
34 insurance. The revised law omits the definition as
35 unnecessary because Section 31.001 of this code

1 defines "commissioner" for purposes of this code and
2 the other insurance laws of this state to mean the
3 commissioner of insurance. The omitted law reads:

4 (5) "Commissioner" means the
5 commissioner of insurance.

6 (5) Section 2(6), V.T.I.C. Article 21.58A,
7 refers to "including but not limited to." "[B]ut not
8 limited to" is omitted as unnecessary because Section
9 311.005(13), Government Code (Code Construction Act),
10 applicable to the revised law, and Section
11 312.011(19), Government Code, provide that "includes"
12 and "including" are terms of enlargement and not of
13 limitation and do not create a presumption that
14 components not expressed are excluded.

15 (6) Section 2(7), V.T.I.C. Article 21.58A,
16 defines the term "dental plan." The revised law omits
17 the term as unnecessary because V.T.I.C. Article
18 21.58A does not use the defined term. The omitted law
19 reads:

20 (7) "Dental plan" means an
21 insurance policy or health benefit plan,
22 including a policy written by a company
23 subject to Chapter 20 of this code, that
24 provides coverage for expenses for dental
25 services.

26 (7) Section 2(8), V.T.I.C. Article 21.58A,
27 defines the term "enrollee" in part by referring to an
28 individual covered by a health insurance policy or
29 "plan." The revised law substitutes a reference to
30 "health benefit plan" for "plan" because "health
31 benefit plan" is the defined term under Section 2(9),
32 V.T.I.C. Article 21.58A, revised in this chapter as
33 Section 4201.002(4).

34 (8) Section 2(9), V.T.I.C. Article 21.58A,
35 refers to a health benefit plan other than "health
36 insurance," and Section 2(16), V.T.I.C. Article
37 21.58A, defines the term "patient" in part by

1 referring to "a health benefit plan or health
2 insurance plan." The revised law substitutes a
3 reference to a "health insurance policy" for the
4 references to "health insurance" and "health insurance
5 plan" because "health insurance policy," rather than
6 "health insurance" or "health insurance plan," is the
7 defined term under Section 2(11), V.T.I.C. Article
8 21.58A, revised in this chapter as Section
9 4201.002(6).

10 (9) Section 2(14), V.T.I.C. Article 21.58A,
11 defines "open meetings law" to mean Chapter 551,
12 Government Code. The revised law omits the definition
13 as unnecessary and substitutes a reference to Chapter
14 551, Government Code, which is the open meetings law,
15 for references to the "open meetings law" throughout
16 this chapter. The omitted law reads:

17 (14) "Open meetings law" means
18 Chapter 551, Government Code.

19 (10) Section 2(15), V.T.I.C. Article 21.58A,
20 defines "open records law" to mean Chapter 552,
21 Government Code. Chapter 1035, Acts of the 74th
22 Legislature, Regular Session, 1995, changed the
23 heading of Chapter 552, Government Code, from "Open
24 Records" to "Public Information." The revised law
25 omits the definition as unnecessary and substitutes a
26 reference to Chapter 552, Government Code, which is
27 the public information law, for references to the
28 "open records law" throughout this chapter. The
29 omitted law reads:

30 (15) "Open records law" means
31 Chapter 552, Government Code.

32 Revised Law

33 Sec. 4201.003. RULES. (a) The commissioner may adopt rules
34 to implement this chapter.

35 (b) A rule adopted under this chapter relates only to a

1 person or entity subject to this chapter.

2 (c) The commissioner shall appoint an advisory committee to
3 advise the commissioner on development of rules regarding the
4 administration of this chapter, as authorized by Section 2001.031,
5 Government Code. The committee includes:

6 (1) the public counsel appointed under Chapter 501;
7 and

8 (2) one representative for each of the following:

9 (A) insurers;

10 (B) health maintenance organizations;

11 (C) group hospital service corporations;

12 (D) utilization review agents;

13 (E) employers;

14 (F) consumer organizations;

15 (G) physicians;

16 (H) dentists;

17 (I) hospitals;

18 (J) registered nurses; and

19 (K) other health care providers.

20 (d) The advisory committee's deliberations are subject to
21 Chapter 551, Government Code. (V.T.I.C. Art. 21.58A, Secs. 13,
22 14(f).)

23 Source Law

24 Sec. 13. The commissioner may have the
25 authority to adopt rules and regulations to implement
26 the provisions of this article. The commissioner
27 shall appoint an advisory committee to advise the
28 commissioner in developing rules and regulations to
29 administer this article as authorized by Section
30 2001.031, Government Code. The committee's
31 deliberations shall be subject to the open meetings
32 law. The committee shall include the public counsel
33 and one representative for each of the following:
34 insurance companies, health maintenance
35 organizations, group hospital service corporations,
36 utilization review agents, employers, consumer
37 organizations, physicians, dentists, hospitals,
38 registered nurses, and other health care providers.

39 [Sec. 14]

40 (f) Any regulations promulgated pursuant to
41 this article shall relate only to persons or entities
42 subject to this article.

1 the later of:

2 (A) the date the call was received; or

3 (B) the date the details necessary to respond
4 have been received from the caller.

5 (b) A utilization review agent must provide to the
6 commissioner a written description of the procedures to be used
7 when responding with respect to poststabilization care subsequent
8 to emergency treatment as requested by a treating physician or
9 other health care provider. (V.T.I.C. Art. 21.58A, Sec. 7.)

10 Source Law

11 Sec. 7. (a) A utilization review agent shall
12 have appropriate personnel reasonably available by
13 toll-free telephone at least 40 hours per week during
14 normal business hours in Texas to discuss patients'
15 care and allow response to telephone review requests.

16 (b) A utilization review agent must have a
17 telephone system capable of accepting or recording or
18 providing instructions to incoming phone calls during
19 other than normal business hours and shall respond to
20 such calls not later than two working days of the later
21 of the date on which the call was received or the date
22 the details necessary to respond have been received
23 from the caller.

24 (c) A utilization review agent must provide a
25 written description to the commissioner setting forth
26 the procedures to be used when responding to
27 poststabilization care subsequent to emergency
28 treatment as requested by a treating physician or
29 health care provider.

30 [Sections 4201.005-4201.050 reserved for expansion]

31 SUBCHAPTER B. APPLICABILITY OF CHAPTER

32 Revised Law

33 Sec. 4201.051. PERSONS PROVIDING INFORMATION ABOUT SCOPE OF
34 COVERAGE OR BENEFITS. This chapter does not apply to a person who:

35 (1) provides information to an enrollee about scope of
36 coverage or benefits provided under a health insurance policy or
37 health benefit plan; and

38 (2) does not determine whether a particular health
39 care service provided or to be provided to an enrollee is medically
40 necessary or appropriate. (V.T.I.C. Art. 21.58A, Sec. 14(a).)

41 Source Law

42 Sec. 14. (a) This article shall not apply to a
43 person who provides information to enrollees about
44 scope of coverage or benefits provided under a health

1 insurance policy or health benefit plan and who does
2 not determine whether particular health care services
3 provided or to be provided to an enrollee are medically
4 necessary or appropriate.

5 Revised Law

6 Sec. 4201.052. CERTAIN CONTRACTS WITH FEDERAL GOVERNMENT.
7 This chapter does not apply to a contract with the federal
8 government to provide utilization review with respect to a patient
9 who is eligible for services under Title XVIII or XIX of the Social
10 Security Act (42 U.S.C. Section 1395 et seq. or Section 1396 et
11 seq.). (V.T.I.C. Art. 21.58A, Sec. 14(b)(1).)

12 Source Law

13 (b)(1) This article shall not apply to any
14 contract with the federal government for utilization
15 review of patients eligible for services under Title
16 XVIII or XIX of the Social Security Act (42 U.S.C.
17 Section 1395 et seq. or Section 1396 et seq.).

18 Revised Law

19 Sec. 4201.053. MEDICAID AND CERTAIN OTHER STATE HEALTH OR
20 MENTAL HEALTH PROGRAMS. Except as provided by Section 4201.057,
21 this chapter does not apply to:

22 (1) the state Medicaid program;

23 (2) the services program for children with special
24 health care needs under Chapter 35, Health and Safety Code;

25 (3) a program administered under Title 2, Human
26 Resources Code;

27 (4) a program of the Department of State Health
28 Services relating to mental health services;

29 (5) a program of the Department of Aging and
30 Disability Services relating to mental retardation services; or

31 (6) a program of the Texas Department of Criminal
32 Justice. (V.T.I.C. Art. 21.58A, Sec. 14(b)(2).)

33 Source Law

34 (2) Except as provided by Subsection (g)
35 of this section, this article shall not apply to the
36 Texas Medicaid Program, the services program for
37 children with special health care needs created
38 pursuant to Chapter 35, Health and Safety Code, any
39 program administered under Title 2, Human Resources
40 Code, any program of the Texas Department of Mental
41 Health and Mental Retardation, or any program of the
42 Texas Department of Criminal Justice.

1 Revisor's Note

2 Section 14(b)(2), V.T.I.C. Article 21.58A,
3 refers to a program of the Texas Department of Mental
4 Health and Mental Retardation. In Chapter 198, Acts of
5 the 78th Legislature, Regular Session, 2003, the
6 legislature directed the consolidation of health and
7 human services agencies and programs. Under the
8 authority of Section 1.26 of that act, the Texas
9 Department of Mental Health and Mental Retardation was
10 abolished. The programs and functions of that
11 department were transferred under Sections 1.19 and
12 1.20 of the act to the Department of State Health
13 Services and the Department of Aging and Disability
14 Services, respectively. The revised law is drafted
15 accordingly.

16 Revised Law

17 Sec. 4201.054. WORKERS' COMPENSATION BENEFITS. (a) Except
18 as provided by this section, this chapter applies to utilization
19 review of a health care service provided to a person eligible for
20 workers' compensation medical benefits under Title 5, Labor Code.
21 The commissioner shall regulate as provided by this chapter a
22 person who performs utilization review of a medical benefit
23 provided under Chapter 408, Labor Code.

24 (b) This section does not affect the authority of the Texas
25 Workers' Compensation Commission to exercise the powers granted to
26 that commission under Title 5, Labor Code.

27 (c) Title 5, Labor Code, prevails in the event of a conflict
28 between this chapter and Title 5, Labor Code.

29 (d) The commissioner and the Texas Workers' Compensation
30 Commission may adopt rules and enter into memoranda of
31 understanding as necessary to implement this section. (V.T.I.C.
32 Art. 21.58A, Sec. 14(c).)

33 Source Law

34 (c) Except as otherwise provided by this

subsection, this article applies to utilization review of health care services provided to persons eligible for workers' compensation medical benefits under Title 5, Labor Code. The commissioner shall regulate in the manner provided by this article a person who performs review of a medical benefit provided under Chapter 408, Labor Code. This subsection does not affect the authority of the Texas Workers' Compensation Commission to exercise the powers granted to that commission under Title 5, Labor Code. In the event of a conflict between this article and Title 5, Labor Code, Title 5, Labor Code, prevails. The commissioner and the Texas Workers' Compensation Commission may adopt rules and enter into memoranda of understanding as necessary to implement this subsection.

Revised Law

Sec. 4201.055. HEALTH CARE SERVICE PROVIDED UNDER AUTOMOBILE INSURANCE POLICY. This chapter does not apply to utilization review of a health care service provided under an automobile insurance policy or contract that is authorized under Chapter 2301 or Article 5.13-2 or that is issued under Chapter 981. (V.T.I.C. Art. 21.58A, Sec. 14(d).)

Source Law

(d) This article shall not apply to utilization review of health care services provided under a policy or contract of automobile insurance promulgated by the board under Subchapter A, Chapter 5 of this code or issued pursuant to Article 1.14-2 of this code.

Revisor's Note

(1) Section 14(d), V.T.I.C. Article 21.58A, refers to "a policy or contract of automobile insurance promulgated by the board," meaning the State Board of Insurance, "under Subchapter A, Chapter 5 of this code." Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately.

Before the regular session of the 78th Legislature, the commissioner adopted policy forms and endorsements for automobile insurance under V.T.I.C. Article 5.06. Chapter 206, Acts of the 78th

1 Legislature, Regular Session, 2003, amended Article
2 5.06 to provide that, effective June 11, 2003, forms
3 for automobile insurance are regulated under V.T.I.C.
4 Article 5.13-2, which is revised in part as Subchapter
5 A, Chapter 2301. That act also amended Article 5.06
6 and V.T.I.C. Article 5.145, revised in relevant part
7 as Subchapter B, Chapter 2301, to authorize insurers
8 to continue to use policy forms and endorsements for
9 personal automobile insurance promulgated, approved,
10 or adopted by the commissioner under Article 5.06
11 before June 11, 2003, on notification to the
12 commissioner. For that reason, the revised law
13 substitutes a reference to "an automobile insurance
14 policy or contract that is authorized under Chapter
15 2301 or Article 5.13-2" for the reference to "a policy
16 or contract of automobile insurance promulgated . . .
17 under Subchapter A, Chapter 5."

18 (2) Section 14(d), V.T.I.C. Article 21.58A,
19 refers to an automobile insurance policy or contract
20 "issued pursuant to Article 1.14-2 of this code."
21 V.T.I.C. Article 1.14-2 was revised in various
22 chapters in this code. The relevant provisions are
23 revised in Chapter 981 of this code, and the revised
24 law is drafted accordingly.

25 Revised Law

26 Sec. 4201.056. EMPLOYEE WELFARE BENEFIT PLANS. This
27 chapter does not apply to the terms or benefits of an employee
28 welfare benefit plan defined by Section 3(1) of the Employee
29 Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(1)).
30 (V.T.I.C. Art. 21.58A, Sec. 14(e).)

31 Source Law

32 (e) This article shall not apply to the terms or
33 benefits of employee welfare benefit plans as defined
34 in Section 3(1) of the Employee Retirement Income
35 Security Act of 1974 (29 U.S.C. Section 1002(1)).

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(f) This chapter does not prohibit or limit the distribution of a portion of the savings from the reduction or elimination of unnecessary medical services, treatment, supplies, confinements, or days of confinement in a health care facility through profit sharing, bonus, or withholding arrangements to a participating physician or participating health care provider for providing health care services to an enrollee. (V.T.I.C. Art. 21.58A, Secs. 14(g), (i) (part).)

1 law omits the reference because Section 10 was
2 repealed by Chapter 703, Acts of the 77th Legislature,
3 Regular Session, 2001.

4 (3) Section 14(g)(2), V.T.I.C. Article 21.58A,
5 refers to the assessment of maintenance taxes under
6 "Article 20A.33, Texas Health Maintenance
7 Organization Act (Article 20A.33, Vernon's Texas
8 Insurance Code)." V.T.I.C. Article 20A.33 was revised
9 in various chapters in this code. The portions of
10 Article 20A.33 relating to imposition of maintenance
11 taxes on health maintenance organizations are revised
12 as Chapter 258 of this code. The revised law is drafted
13 accordingly.

14 (4) Section 14(i), V.T.I.C. Article 21.58A,
15 requires a health maintenance organization that
16 performs utilization review for certain persons or
17 entities to obtain a certificate of registration under
18 Section 3, Article 21.58A, revised in this chapter as
19 Subchapter C. The revised law adds the phrase
20 "[n]otwithstanding Subsection (c)(1)" to this
21 provision to clarify that the relevant portion of
22 Section 14(i), revised as Section 4201.057(e), is an
23 exception to the exemption from the requirement to
24 obtain a certificate of registration that is provided
25 by Section 14(g)(1), Article 21.58A, revised in
26 relevant part as Section 4201.057(c)(1).

27 Revised Law

28 Sec. 4201.058. INSURERS. (a) This chapter applies to an
29 insurer subject to this code that delivers or issues for delivery a
30 health insurance policy in this state except as expressly provided
31 by this section. As a condition of holding a certificate of
32 authority to engage in the business of insurance, an insurer that
33 performs utilization review shall comply with this chapter, except
34 Subchapter C. The insurer is subject to assessment of a maintenance

1 tax under Chapter 257 to cover the costs of administering
2 compliance with this subsection.

3 (b) The commissioner shall adopt rules for appropriate
4 verification and enforcement of compliance with Subsection (a).

5 (c) Notwithstanding Subsection (a), an insurer subject to
6 this code that performs utilization review for a person or entity
7 subject to this chapter, other than a person or entity for which the
8 insurer is the payor, must obtain a certificate of registration
9 under Subchapter C and shall comply with all of the provisions of
10 this chapter. (V.T.I.C. Art. 21.58A, Secs. 14(h), (i) (part).)

11 Source Law

12 (h) An insurer which delivers or issues for
13 delivery a health insurance policy in Texas and is
14 subject to this code is subject to this article except
15 as expressly provided in this subsection and
16 Subsection (i) of this section. If an insurer performs
17 utilization review as defined herein it shall, as a
18 condition of licensure, comply with this article,
19 except Sections 3 and 10, and the commissioner shall
20 promulgate rules for appropriate verification and
21 enforcement of compliance. Such insurers shall be
22 subject to assessment of maintenance tax under Article
23 4.17 of this code to cover the costs of administering
24 compliance of insurers under this section.

25 (i) However, when an insurer subject to this
26 code or . . . performs utilization review for a person
27 or entity subject to this article other than one for
28 which it is the payor, such insurer or . . . shall be
29 required to obtain a certificate under Section 3 of
30 this article and comply with all the provisions of this
31 article.

32 Revisor's Note

33 (1) Section 14(h), V.T.I.C. Article 21.58A,
34 imposes certain duties "as a condition of licensure"
35 on certain insurers that perform utilization review.
36 The revised law substitutes "[a]s a condition of
37 holding a certificate of authority to engage in the
38 business of insurance" for "[a]s a condition of
39 licensure" because, under this code, an insurer is
40 required to obtain a certificate of authority to
41 engage in the business of insurance in this state.

42 (2) Section 14(h), V.T.I.C. Article 21.58A,
43 refers to Section 10 of Article 21.58A. The revised

1 law omits the reference for the reason stated in
2 Revisor's Note (2) to Section 4201.057.

3 (3) Section 14(h), V.T.I.C. Article 21.58A,
4 refers to the assessment of a maintenance tax under
5 "Article 4.17 of this code." V.T.I.C. Article 4.17 was
6 revised in various chapters in this code. The relevant
7 provisions are revised in Chapter 257 of this code.
8 The revised law is drafted accordingly.

9 (4) Section 14(i), V.T.I.C. Article 21.58A,
10 requires an insurer that performs utilization review
11 for certain persons or entities to obtain a
12 certificate of registration under Section 3, Article
13 21.58A, revised in this chapter as Subchapter C. The
14 revised law adds the phrase "[n]otwithstanding
15 Subsection (a)" to this provision to clarify that the
16 relevant portion of Section 14(i), revised as Section
17 4201.058(c), is an exception to the exemption from the
18 requirement to obtain a certificate of registration
19 that is provided by Section 14(h), Article 21.58A,
20 revised in relevant part as Section 4201.058(a).

21 [Sections 4201.059-4201.100 reserved for expansion]

22 SUBCHAPTER C. CERTIFICATION

23 Revised Law

24 Sec. 4201.101. CERTIFICATE OF REGISTRATION REQUIRED. A
25 utilization review agent may not conduct utilization review unless
26 the commissioner issues a certificate of registration to the agent
27 under this subchapter. (V.T.I.C. Art. 21.58A, Secs. 2 (part),
28 3(a).)

29 Source Law

30 Sec. 2. [In this article:]

31 . . .
32 (4) ["Certificate" means a certificate of
33 registration] granted by the commissioner to a
34 utilization review agent.
35 . . .

36 Sec. 3. (a) A utilization review agent may not
37 conduct utilization review of health care provided in

1 this state unless the commissioner has granted the
2 utilization review agent a certificate pursuant to
3 this article.

4 Revisor's Note

5 Section 3(a), V.T.I.C. Article 21.58A, refers to
6 utilization review of "health care provided in this
7 state." The revised law omits the quoted phrase
8 because it duplicates the definition of "utilization
9 review" in Section 2(20), V.T.I.C. Article 21.58A,
10 revised in this chapter as Section 4201.002(13).

11 Revised Law

12 Sec. 4201.102. REQUIREMENTS FOR CERTIFICATION. (a) The
13 commissioner may issue a certificate of registration only to an
14 applicant who has met all the requirements of this chapter and all
15 applicable rules adopted by the commissioner.

16 (b) As a condition of holding a certificate of registration
17 or renewal of a certificate, a utilization review agent must
18 maintain compliance with Subchapters D, E, and F. (V.T.I.C. Art.
19 21.58A, Secs. 3(b), 4(a).)

20 Source Law

21 [Sec. 3]

22 (b) The commissioner may only issue a
23 certificate to an applicant that has met all the
24 requirements of this article and all applicable rules
25 and regulations of the commissioner.

26 Sec. 4. (a) As a condition of certification or
27 renewal thereof, a utilization review agent shall be
28 required to maintain compliance with the provisions of
29 this section.

30 Revised Law

31 Sec. 4201.103. CERTIFICATE RENEWAL. Certification may be
32 renewed biennially by filing, not later than March 1, a renewal form
33 with the commissioner accompanied by a fee in an amount set by the
34 commissioner. (V.T.I.C. Art. 21.58A, Sec. 3(d).)

35 Source Law

36 (d) Certification may be renewed biennially by
37 filing, not later than March 1, a renewal form with the
38 commissioner accompanied by a renewal fee in an amount
39 set by the commissioner.

1 oral and written complaints by enrollees, patients, or
2 health care providers.

3 Revisor's Note

4 (1) Section 3(e)(5), V.T.I.C. Article 21.58A,
5 refers to procedures for appeal of an adverse
6 determination established by a utilization review
7 agent. For the reader's convenience, the revised law
8 adds a cross-reference to Subchapter H because that
9 subchapter, which is derived from Section 6, V.T.I.C.
10 Article 21.58A, requires those procedures.

11 (2) Section 3(e)(7), V.T.I.C. Article 21.58A,
12 refers to procedures for handling certain complaints
13 concerning utilization review. For the reader's
14 convenience, the revised law adds a cross-reference to
15 Section 4201.204 because that section, which is
16 derived from Section 4(m), V.T.I.C. Article 21.58A,
17 requires a utilization review agent to establish those
18 procedures.

19 Revised Law

20 Sec. 4201.105. FEES. The commissioner shall establish,
21 administer, and enforce the fees for initial certification and
22 certification renewal in amounts that do not exceed the amounts
23 necessary to cover the cost of administering this chapter.
24 (V.T.I.C. Art. 21.58A, Sec. 3(f).)

25 Source Law

26 (f) The commissioner shall establish,
27 administer, and enforce the certification and renewal
28 fees under this section in amounts not greater than
29 that necessary to cover the cost of administration of
30 this article.

31 Revised Law

32 Sec. 4201.106. CERTIFICATE NOT TRANSFERABLE. A certificate
33 of registration is not transferable. (V.T.I.C. Art. 21.58A, Sec.
34 3(c).)

35 Source Law

36 (c) A certificate issued under this article is
37 not transferable.

1 Revised Law

2 Sec. 4201.107. REPORTING MATERIAL CHANGES. A utilization
3 review agent shall report any material change to the information
4 disclosed in a form filed under this subchapter not later than the
5 30th day after the date the change takes effect. (V.T.I.C. Art.
6 21.58A, Sec. 3(g).)

7 Source Law

8 (g) A utilization review agent shall report any
9 material changes in the information in a certification
10 or renewal form filed under this section not later than
11 the 30th day after the date on which the change takes
12 effect.

13 Revisor's Note

14 Section 3(g), V.T.I.C. Article 21.58A, refers to
15 a certification or renewal form filed under "this
16 section," meaning Section 3, V.T.I.C. Article 21.58A.
17 Although this subchapter contains provisions derived
18 from other sections of Article 21.58A, the revised law
19 substitutes "this subchapter" for "this section"
20 because the only provisions in this subchapter that
21 relate to filing forms are derived from Section 3.

22 Revised Law

23 Sec. 4201.108. LIST OF UTILIZATION REVIEW AGENTS. (a) The
24 commissioner shall maintain and update monthly a list of each
25 utilization review agent to whom a certificate of registration has
26 been issued and the renewal date of the certificate.

27 (b) The commissioner shall provide the list at cost to each
28 individual or organization requesting the list. (V.T.I.C. Art.
29 21.58A, Sec. 12.)

30 Source Law

31 Sec. 12. The commissioner shall maintain and
32 update monthly a list of utilization review agents
33 issued certificates and the renewal date for those
34 certificates. The commissioner shall provide the list
35 at cost to all individuals or organizations requesting
36 the list.

37 [Sections 4201.109-4201.150 reserved for expansion]

1 SUBCHAPTER D. UTILIZATION REVIEW: GENERAL STANDARDS

2 Revised Law

3 Sec. 4201.151. UTILIZATION REVIEW PLAN. A utilization
4 review agent's utilization review plan, including reconsideration
5 and appeal requirements, must be reviewed by a physician and
6 conducted in accordance with standards developed with input from
7 appropriate health care providers and approved by a physician.
8 (V.T.I.C. Art. 21.58A, Sec. 4(b).)

9 Source Law

10 (b) The utilization review plan, including
11 reconsideration and appeal requirements, shall be
12 reviewed by a physician and conducted in accordance
13 with standards developed with input from appropriate
14 health care providers and approved by a physician.

15 Revised Law

16 Sec. 4201.152. UTILIZATION REVIEW UNDER DIRECTION OF
17 PHYSICIAN. A utilization review agent shall conduct utilization
18 review under the direction of a physician licensed to practice
19 medicine by a state licensing agency in the United States.
20 (V.T.I.C. Art. 21.58A, Sec. 4(h).)

21 Source Law

22 (h) Utilization review conducted by a
23 utilization review agent shall be under the direction
24 of a physician licensed to practice medicine by a state
25 licensing agency in the United States.

26 Revised Law

27 Sec. 4201.153. SCREENING CRITERIA AND REVIEW PROCEDURES.

28 (a) A utilization review agent shall use written medically
29 acceptable screening criteria and review procedures that are
30 established and periodically evaluated and updated with
31 appropriate involvement from physicians, including practicing
32 physicians, dentists, and other health care providers.

33 (b) A utilization review determination shall be made in
34 accordance with currently accepted medical or health care
35 practices, taking into account special circumstances of the case
36 that may require deviation from the norm stated in the screening
37 criteria.

1 (c) Screening criteria must be:

2 (1) objective;

3 (2) clinically valid;

4 (3) compatible with established principles of health
5 care; and

6 (4) flexible enough to allow a deviation from the norm
7 when justified on a case-by-case basis.

8 (d) Screening criteria must be used to determine only
9 whether to approve the requested treatment. A denial of requested
10 treatment must be referred to an appropriate physician, dentist, or
11 other health care provider to determine medical necessity.
12 (V.T.I.C. Art. 21.58A, Sec. 4(i) (part).)

13 Source Law

14 (i) Each utilization review agent shall utilize
15 written medically acceptable screening criteria and
16 review procedures which are established and
17 periodically evaluated and updated with appropriate
18 involvement from physicians, including practicing
19 physicians, dentists, and other health care providers.
20 Utilization review decisions shall be made in
21 accordance with currently accepted medical or health
22 care practices, taking into account special
23 circumstances of each case that may require deviation
24 from the norm stated in the screening criteria.
25 Screening criteria must be objective, clinically
26 valid, compatible with established principles of
27 health care, and flexible enough to allow deviations
28 from the norms when justified on a case-by-case basis.
29 Screening criteria must be used to determine only
30 whether to approve the requested treatment. Denials
31 must be referred to an appropriate physician, dentist,
32 or other health care provider to determine medical
33 necessity. . . .

34 Revised Law

35 Sec. 4201.154. REVIEW AND INSPECTION OF SCREENING CRITERIA
36 AND REVIEW PROCEDURES. (a) A utilization review agent's written
37 screening criteria and review procedures shall be made available
38 for:

39 (1) review and inspection to determine
40 appropriateness and compliance as considered necessary by the
41 commissioner; and

42 (2) copying as necessary for the commissioner to
43 accomplish the commissioner's duties under this code.

1 (b) Any information obtained or acquired under the
2 authority of this section, Section 4201.153, and this chapter is
3 confidential and privileged and is not subject to Chapter 552,
4 Government Code, or to subpoena except to the extent necessary for
5 the commissioner to enforce this chapter. (V.T.I.C. Art. 21.58A,
6 Sec. 4(i) (part).)

7 Source Law

8 (i) . . . Such written screening criteria and
9 review procedures shall be available for review and
10 inspection to determine appropriateness and
11 compliance as deemed necessary by the commissioner and
12 copying as necessary for the commissioner to carry out
13 his or her lawful duties under this code, provided,
14 however, that any information obtained or acquired
15 under the authority of this subsection and article is
16 confidential and privileged and not subject to the
17 open records law or subpoena except to the extent
18 necessary for the commissioner to enforce this
19 article.

20 Revisor's Note

21 Section 4(i), V.T.I.C. Article 21.58A, refers to
22 the "lawful duties" of the commissioner of insurance.
23 The revised law omits "lawful" as unnecessary because
24 all of a public official's duties are imposed by law.

25 Revised Law

26 Sec. 4201.155. LIMITATION ON NOTICE REQUIREMENTS AND REVIEW
27 PROCEDURES. A utilization review agent may not establish or impose
28 a notice requirement or other review procedure that is contrary to
29 the requirements of the health insurance policy or health benefit
30 plan. (V.T.I.C. Art. 21.58A, Sec. 4(d).)

31 Source Law

32 (d) A utilization review agent shall not set or
33 impose any notice or other review procedures contrary
34 to the requirements of the health insurance policy or
35 health benefit plan.

36 [Sections 4201.156-4201.200 reserved for expansion]

37 SUBCHAPTER E. UTILIZATION REVIEW: RELATIONS WITH PATIENTS AND
38 HEALTH CARE PROVIDERS

39 Revised Law

40 Sec. 4201.201. REPETITIVE CONTACTS WITH HEALTH CARE
41 PROVIDER OR PATIENT; FREQUENCY OF REVIEWS. A utilization review

1 agent:

2 (1) may not engage in unnecessary or unreasonable
3 repetitive contacts with a health care provider or patient; and

4 (2) shall base the frequency of contacts or reviews on
5 the severity or complexity of the patient's condition or on
6 necessary treatment and discharge planning activity. (V.T.I.C.
7 Art. 21.58A, Sec. 4(j).)

8 Source Law

9 (j) A utilization review agent may not engage in
10 unnecessary or unreasonable repetitive contacts with
11 the health care provider or patient and shall base the
12 frequency of contacts or reviews on the severity or
13 complexity of the patient's condition or on necessary
14 treatment and discharge planning activity.

15 Revised Law

16 Sec. 4201.202. OBSERVING OR PARTICIPATING IN PATIENT'S
17 CARE. (a) Unless approved for an individual patient by the
18 provider of record or modified by contract, a utilization review
19 agent shall be prohibited from observing, participating in, or
20 otherwise being present during a patient's examination, treatment,
21 procedure, or therapy.

22 (b) This subchapter, Subchapters D and F, and Section
23 4201.102(b) may not be construed to otherwise limit or deny contact
24 with a patient for purposes of conducting utilization review unless
25 otherwise specifically prohibited by law. (V.T.I.C. Art. 21.58A,
26 Sec. 4(e).)

27 Source Law

28 (e) Unless approved for an individual patient by
29 the provider of record or modified by contract, a
30 utilization review agent shall be prohibited from
31 observing, participating in, or otherwise being
32 present during a patient's examination, treatment,
33 procedure, or therapy. In no event shall this section
34 otherwise be construed to limit or deny contact with a
35 patient for purposes of conducting utilization review
36 unless otherwise specifically prohibited by law.

37 Revised Law

38 Sec. 4201.203. MENTAL HEALTH THERAPY. (a) A utilization
39 review agent may not require, as a condition of treatment approval
40 or for any other reason, the observation of a psychotherapy session

1 or the submission or review of a mental health therapist's process
2 or progress notes.

3 (b) Notwithstanding this section, a utilization review
4 agent may require submission of a patient's medical record summary.
5 (V.T.I.C. Art. 21.58A, Sec. 4(o).)

6 Source Law

7 (o) A utilization review agent may not require,
8 as a condition of treatment approval or for any other
9 reason, the observation of a psychotherapy session or
10 the submission or review of a mental health therapist's
11 process or progress notes. Notwithstanding this
12 subsection, a utilization review agent may require
13 submission of a patient's medical record summary.

14 Revised Law

15 Sec. 4201.204. COMPLAINT SYSTEM. (a) A utilization review
16 agent shall establish and maintain a complaint system that provides
17 reasonable procedures for the resolution of oral or written
18 complaints initiated by enrollees, patients, or health care
19 providers concerning the utilization review.

20 (b) The complaint procedure must include a requirement that
21 the utilization review agent provide a written response to the
22 complainant within 30 days.

23 (c) A utilization review agent shall submit to the
24 commissioner a summary report of all complaints at the times and in
25 the form specified by the commissioner. The agent shall allow the
26 commissioner to examine the complaints and relevant documents at
27 any time.

28 (d) A utilization review agent shall maintain a record of
29 each complaint until the third anniversary of the date the
30 complainant filed the complaint. (V.T.I.C. Art. 21.58A, Sec.
31 4(m).)

32 Source Law

33 (m) A utilization review agent shall establish
34 and maintain a complaint system that provides
35 reasonable procedures for the resolution of oral or
36 written complaints initiated by enrollees, patients,
37 or health care providers concerning the utilization
38 review and shall maintain records of such complaints
39 for three years from the time the complaints are filed.
40 The complaint procedure shall include a written
41 response to the complainant by the agent within 30

1 days. The utilization review agent shall submit to the
2 commissioner a summary report of all complaints at
3 such times and in such forms as the commissioner may
4 require and shall permit the commissioner to examine
5 the complaints and all relevant documents at any time.

6 Revised Law

7 Sec. 4201.205. DESIGNATED INITIAL CONTACT. (a) A health
8 care provider may designate one or more individuals as the initial
9 contact or contacts for a utilization review agent seeking routine
10 information or data.

11 (b) A designation made under this section may not preclude a
12 utilization review agent or medical advisor from contacting a
13 health care provider or the provider's employees who are not
14 designated under this section under circumstances in which:

15 (1) a review might otherwise be unreasonably delayed;
16 or

17 (2) the designated individual is unable to provide the
18 necessary data or information that the agent requests. (V.T.I.C.
19 Art. 21.58A, Sec. 4(g).)

20 Source Law

21 (g) A health care provider may designate one or
22 more individuals as the initial contact or contacts
23 for utilization review agents seeking routine
24 information or data. In no event shall the designation
25 of such an individual or individuals preclude a
26 utilization review agent or medical advisor from
27 contacting a health care provider or others in his or
28 her employ where a review might otherwise be
29 unreasonably delayed or where the designated
30 individual is unable to provide the necessary
31 information or data requested by the utilization
32 review agent.

33 Revised Law

34 Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE
35 ADVERSE DETERMINATION. Subject to the notice requirements of
36 Subchapter G, before a utilization review agent who questions the
37 medical necessity or appropriateness of a health care service
38 issues an adverse determination, the agent shall provide the health
39 care provider who ordered the service a reasonable opportunity to
40 discuss with a physician the patient's treatment plan and the
41 clinical basis for the agent's determination. (V.T.I.C. Art.
42 21.58A, Sec. 4(k).)

Source Law

(k) Subject to the notice requirements of Section 5 of this article, in any instance where the utilization review agent is questioning the medical necessity or appropriateness of health care services, the health care provider who ordered the services shall be afforded a reasonable opportunity to discuss the plan of treatment for the patient and the clinical basis for the utilization review agent's decision with a physician prior to issuance of an adverse determination.

Revised Law

Sec. 4201.207. CHARGES BY HEALTH CARE PROVIDER FOR PROVIDING MEDICAL INFORMATION. (a) Unless precluded or modified by contract, a utilization review agent shall reimburse a health care provider for the reasonable costs of providing medical information in writing, including the costs of copying and transmitting requested patient records or other documents.

(b) A health care provider's charges for providing medical information to a utilization review agent may not:

(1) exceed the cost of copying records as set by rules adopted by the Texas Workers' Compensation Commission; or

(2) include any costs otherwise recouped as part of the charges for health care. (V.T.I.C. Art. 21.58A, Sec. 4(1).)

Source Law

(1) Unless precluded or modified by contract, a utilization review agent shall reimburse health care providers for the reasonable costs for providing medical information in writing, including copying and transmitting any requested patient records or other documents. A health care provider's charges for providing medical information to a utilization review agent shall not exceed the cost of copying set by rule of the Texas Workers' Compensation Commission for records and may not include any costs that are otherwise recouped as a part of the charge for health care.

[Sections 4201.208-4201.250 reserved for expansion]

SUBCHAPTER F. UTILIZATION REVIEW: PERSONNEL

Revised Law

Sec. 4201.251. DELEGATION OF UTILIZATION REVIEW. A utilization review agent may delegate utilization review to qualified personnel in the hospital or other health care facility in which the health care services to be reviewed were or are to be

1 provided. The delegation does not release the agent from the full
2 responsibility for compliance with this chapter, including the
3 conduct of those to whom utilization review has been delegated.
4 (V.T.I.C. Art. 21.58A, Sec. 4(n).)

5 Source Law

6 (n) The utilization review agent may delegate
7 utilization review to qualified personnel in the
8 hospital or health care facility where the health care
9 services were or are to be provided. However, such
10 delegation shall not relieve the utilization review
11 agent of full responsibility for compliance with this
12 article, including the conduct of those to whom
13 utilization review has been delegated.

14 Revised Law

15 Sec. 4201.252. PERSONNEL. (a) Personnel employed by or
16 under contract with a utilization review agent to perform
17 utilization review must be appropriately trained and qualified.

18 (b) Personnel, other than a physician, who obtain oral or
19 written information directly from a patient's physician or other
20 health care provider regarding the patient's specific medical
21 condition, diagnosis, or treatment options or protocols must be a
22 nurse, physician assistant, or other health care provider qualified
23 to provide the requested service.

24 (c) This section may not be interpreted to require personnel
25 who perform clerical or administrative tasks to have the
26 qualifications prescribed by this section. (V.T.I.C. Art. 21.58A,
27 Sec. 4(c).)

28 Source Law

29 (c) Personnel employed by or under contract with
30 the utilization review agent to perform utilization
31 review shall be appropriately trained and qualified.
32 Personnel who obtain information regarding a patient's
33 specific medical condition, diagnosis, and treatment
34 options or protocols directly from the physician or
35 health care provider, either orally or in writing, and
36 who are not physicians shall be nurses, physician
37 assistants, or health care providers qualified to
38 provide the service requested by the provider. This
39 provision shall not be interpreted to require such
40 qualifications for personnel who perform clerical or
41 administrative tasks.

42 Revised Law

43 Sec. 4201.253. PROHIBITED BASES FOR EMPLOYMENT,

1 COMPENSATION, EVALUATIONS, OR PERFORMANCE STANDARDS. A
2 utilization review agent may not permit or provide compensation or
3 another thing of value to an employee or agent of the utilization
4 review agent, condition employment of the agent's employees or
5 agent evaluations, or set employee or agent performance standards,
6 based on the amount of volume of adverse determinations, reductions
7 of or limitations on lengths of stay, benefits, services, or
8 charges, or the number or frequency of telephone calls or other
9 contacts with health care providers or patients, that are
10 inconsistent with this chapter. (V.T.I.C. Art. 21.58A, Sec. 4(f).)

11 Source Law

12 (f) A utilization review agent may not permit or
13 provide compensation or any thing of value to its
14 employees or agents, condition employment of its
15 employee or agent evaluations, or set its employee or
16 agent performance standards, based on the amount of
17 volume of adverse determinations, reductions or
18 limitations on lengths of stay, benefits, services, or
19 charges or on the number or frequency of telephone
20 calls or other contacts with health care providers or
21 patients, which are inconsistent with the provisions
22 of this article.

23 [Sections 4201.254-4201.300 reserved for expansion]

24 SUBCHAPTER G. NOTICE OF DETERMINATIONS

25 Revised Law

26 Sec. 4201.301. GENERAL DUTY TO NOTIFY. A utilization
27 review agent shall provide notice of a determination made in a
28 utilization review to:

- 29 (1) the enrollee's provider of record; and
30 (2) the enrollee or a person acting on the enrollee's
31 behalf. (V.T.I.C. Art. 21.58A, Sec. 5(a).)

32 Source Law

33 Sec. 5. (a) A utilization review agent shall
34 notify the enrollee or a person acting on behalf of the
35 enrollee and the enrollee's provider of record of a
36 determination made in a utilization review.

37 Revised Law

38 Sec. 4201.302. GENERAL TIME FOR NOTICE. A utilization
39 review agent must mail or otherwise transmit the notice required by
40 this subchapter not later than the second working day after the date

1 of the request for utilization review and the agent receives all
2 information necessary to complete the review. (V.T.I.C. Art.
3 21.58A, Sec. 5(b).)

4 Source Law

5 (b) The notification required by this section
6 must be mailed or otherwise transmitted not later than
7 two working days after the date of the request for
8 utilization review and all information necessary to
9 complete the review is received by the agent.

10 Revised Law

11 Sec. 4201.303. ADVERSE DETERMINATION: CONTENTS OF NOTICE.

12 (a) Notice of an adverse determination must include:

13 (1) the principal reasons for the adverse
14 determination;

15 (2) the clinical basis for the adverse determination;

16 (3) a description of or the source of the screening
17 criteria used as guidelines in making the adverse determination;
18 and

19 (4) a description of the procedure for the complaint
20 and appeal process, including notice to the enrollee of the
21 enrollee's right to appeal an adverse determination to an
22 independent review organization and of the procedures to obtain
23 that review.

24 (b) For an enrollee who has a life-threatening condition,
25 the notice required by Subsection (a)(4) must include a description
26 of the enrollee's right to an immediate review by an independent
27 review organization and of the procedures to obtain that review.
28 (V.T.I.C. Art. 21.58A, Sec. 5(c).)

29 Source Law

30 (c) In the event of an adverse determination,
31 the notification by the utilization review agent must
32 include:

33 (1) the principal reasons for the adverse
34 determination;

35 (2) the clinical basis for the adverse
36 determination;

37 (3) a description or the source of the
38 screening criteria that were utilized as guidelines in
39 making the determination; and

40 (4) a description of the procedure for the
41 complaint and appeal process, including:

42 (A) notification to the enrollee of

1 the enrollee's right to appeal an adverse
2 determination to an independent review organization;

3 (B) notification to the enrollee of
4 the procedures for appealing an adverse determination
5 to an independent review organization; and

6 (C) notification to an enrollee who
7 has a life-threatening condition of the enrollee's
8 right to an immediate review by an independent review
9 organization and the procedures to obtain that review.

10 Revised Law

11 Sec. 4201.304. TIME FOR NOTICE OF ADVERSE DETERMINATION. A
12 utilization review agent shall provide notice of an adverse
13 determination required by this subchapter as follows:

14 (1) with respect to a patient who is hospitalized at
15 the time of the adverse determination, within one working day by
16 either telephone or electronic transmission to the provider of
17 record, followed by a letter within three working days notifying
18 the patient and the provider of record of the adverse
19 determination;

20 (2) with respect to a patient who is not hospitalized
21 at the time of the adverse determination, within three working days
22 in writing to the provider of record and the patient; or

23 (3) within the time appropriate to the circumstances
24 relating to the delivery of the services to the patient and to the
25 patient's condition, provided that when denying poststabilization
26 care subsequent to emergency treatment as requested by a treating
27 physician or other health care provider, the agent shall provide
28 the notice to the treating physician or other health care provider
29 not later than one hour after the time of the request. (V.T.I.C.
30 Art. 21.58A, Sec. 5(d).)

31 Source Law

32 (d) The notification of adverse determination
33 required by this section shall be provided by the
34 utilization review agent:

35 (1) within one working day by telephone or
36 electronic transmission to the provider of record in
37 the case of a patient who is hospitalized at the time
38 of the adverse determination, to be followed by a
39 letter notifying the patient and the provider of
40 record of an adverse determination within three
41 working days;

42 (2) within three working days in writing
43 to the provider of record and the patient if the
44 patient is not hospitalized at the time of the adverse
45 determination; or

1 (3) within the time appropriate to the
2 circumstances relating to the delivery of the services
3 and the condition of the patient, but in no case to
4 exceed one hour from notification when denying
5 poststabilization care subsequent to emergency
6 treatment as requested by a treating physician or
7 provider. In such circumstances, notification shall
8 be provided to the treating physician or health care
9 provider.

10 [Sections 4201.305-4201.350 reserved for expansion]

11 SUBCHAPTER H. APPEAL OF ADVERSE DETERMINATION

12 Revised Law

13 Sec. 4201.351. COMPLAINT AS APPEAL. For purposes of this
14 subchapter, a complaint filed concerning dissatisfaction or
15 disagreement with an adverse determination constitutes an appeal of
16 that adverse determination. (V.T.I.C. Art. 21.58A, Sec. 6(a)
17 (part).)

18 Source Law

19 Sec. 6. (a) . . . For the purposes of this
20 section, a complaint filed concerning dissatisfaction
21 or disagreement with an adverse determination
22 constitutes an appeal of that adverse determination.

23 Revised Law

24 Sec. 4201.352. WRITTEN DESCRIPTION OF APPEAL PROCEDURES. A
25 utilization review agent shall maintain and make available a
26 written description of the procedures for appealing an adverse
27 determination. (V.T.I.C. Art. 21.58A, Sec. 6(a) (part).)

28 Source Law

29 Sec. 6. (a) A utilization review agent shall
30 maintain and make available a written description of
31 appeal procedures involving an adverse
32 determination. . . .

33 Revised Law

34 Sec. 4201.353. APPEAL PROCEDURES MUST BE REASONABLE. The
35 procedures for appealing an adverse determination must be
36 reasonable. (V.T.I.C. Art. 21.58A, Sec. 6(b) (part).)

37 Source Law

38 (b) The procedures for appeals must be
39 reasonable and

40 Revised Law

41 Sec. 4201.354. PERSONS OR ENTITIES WHO MAY APPEAL. The
42 procedures for appealing an adverse determination must provide that

1 the adverse determination may be appealed orally or in writing by:

- 2 (1) an enrollee;
- 3 (2) a person acting on the enrollee's behalf; or
- 4 (3) the enrollee's physician or other health care
- 5 provider. (V.T.I.C. Art. 21.58A, Sec. 6(b) (part).)

6 Source Law

7 (b) The procedures for appeals . . . must

8 include the following:

- 9 (1) a provision that an enrollee, a person
- 10 acting on behalf of the enrollee, or the enrollee's
- 11 physician or health care provider may appeal the
- 12 adverse determination orally or in writing;

13 Revised Law

14 Sec. 4201.355. ACKNOWLEDGMENT OF APPEAL. (a) The

15 procedures for appealing an adverse determination must provide

16 that, within five working days from the date the utilization review

17 agent receives the appeal, the agent shall send to the appealing

18 party a letter acknowledging the date of receipt.

19 (b) The letter must also include a list of:

- 20 (1) the procedures required by this subchapter; and
- 21 (2) the documents that the appealing party must submit
- 22 for review.

23 (c) When a utilization review agent receives an oral appeal

24 of an adverse determination, the agent shall send a one-page appeal

25 form to the appealing party. (V.T.I.C. Art. 21.58A, Sec. 6(b)

26 (part).)

27 Source Law

28 (b) The procedures for appeals . . . must

29 include the following:

- 30 . . .
- 31 (2) a provision that, within five working
- 32 days from receipt of the appeal, the utilization
- 33 review agent shall send to the appealing party a letter
- 34 acknowledging the date of the utilization review
- 35 agent's receipt of the appeal. The letter must also
- 36 include the provisions listed in this subsection and a
- 37 list of the documents that the appealing party must
- 38 submit for review by the utilization review agent.
- 39 When the utilization review agent receives an oral
- 40 appeal of adverse determination, the utilization
- 41 review agent shall send a one-page appeal form to the
- 42 appealing party;

Revised Law

Sec. 4201.356. DECISION BY PHYSICIAN REQUIRED; SPECIALTY REVIEW. (a) The procedures for appealing an adverse determination must provide that a physician makes the decision on the appeal, except as provided by Subsection (b).

(b) If not later than the 10th working day after the date an appeal is denied the enrollee's health care provider states in writing good cause for having a particular type of specialty provider review the case, a health care provider who is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under consideration for review shall review the decision denying the appeal. The specialty review must be completed within 15 working days of the date the health care provider's request for specialty review is received. (V.T.I.C. Art. 21.58A, Sec. 6(b) (part).)

Source Law

(b) The procedures for appeals . . . must include the following:

(3) a provision that appeal decisions shall be made by a physician, provided that, if the appeal is denied and within 10 working days the health care provider sets forth in writing good cause for having a particular type of a specialty provider review the case, the denial shall be reviewed by a health care provider in the same or similar specialty as typically manages the medical or dental condition, procedure, or treatment under discussion for review of the adverse determination, and that specialty review shall be completed within 15 working days of receipt of the request;

Revised Law

Sec. 4201.357. EXPEDITED APPEAL FOR DENIAL OF EMERGENCY CARE OR CONTINUED HOSPITALIZATION. (a) The procedures for appealing an adverse determination must include, in addition to the written appeal, a procedure for an expedited appeal of a denial of emergency care or a denial of continued hospitalization. That procedure must include a review by a health care provider who:

(1) has not previously reviewed the case; and

(2) is of the same or a similar specialty as the health

1 care provider who would typically manage the medical or dental
2 condition, procedure, or treatment under review in the appeal.

3 (b) The time for resolution of an expedited appeal under
4 this section shall be based on the medical or dental immediacy of
5 the condition, procedure, or treatment under review, provided that
6 the resolution of the appeal may not exceed one working day from the
7 date all information necessary to complete the appeal is received.
8 (V.T.I.C. Art. 21.58A, Sec. 6(b) (part).)

9 Source Law

10 (b) The procedures for appeals . . . must
11 include the following:

12 . . .
13 (4) in addition to the written appeal, a
14 method for an expedited appeal procedure for emergency
15 care denials and denials of continued stays for
16 hospitalized patients. That procedure must include a
17 review by a health care provider who has not previously
18 reviewed the case and who is of the same or a similar
19 specialty as typically manages the medical condition,
20 procedure, or treatment under review. The time frame
21 in which the appeal must be completed shall be based on
22 the medical or dental immediacy of the condition,
23 procedure, or treatment, but may not exceed one
24 working day from the date all information necessary to
25 complete the appeal is received;

26 Revisor's Note

27 Section 6(b)(4), V.T.I.C. Article 21.58A, refers
28 to a health care provider who is of the same or a
29 similar specialty as the health care provider who
30 would typically manage the "medical condition,
31 procedure, or treatment under review." The revised
32 law substitutes "medical or dental" for "medical"
33 because it is clear from the context of the source law,
34 including the reference in the source law to the
35 "medical or dental" immediacy of the condition, that
36 the case under review may involve a medical or dental
37 condition, procedure, or treatment.

38 Revised Law

39 Sec. 4201.358. RESPONSE LETTER TO INTERESTED PERSONS. The
40 procedures for appealing an adverse determination must provide
41 that, after the utilization review agent has sought review of the

1 appeal, the agent shall issue a response letter explaining the
2 resolution of the appeal to:

3 (1) the patient or a person acting on the patient's
4 behalf; and

5 (2) the patient's physician or other health care
6 provider. (V.T.I.C. Art. 21.58A, Sec. 6(b) (part).)

7 Source Law

8 (b) The procedures for appeals . . . must
9 include the following:

10 . . .
11 (5) a provision that after the utilization
12 review agent has sought review of the appeal of the
13 adverse determination, the utilization review agent
14 shall issue a response letter to the patient or a
15 person acting on behalf of the patient, and the
16 patient's physician or health care provider,
17 explaining the resolution of the appeal; and

18 Revised Law

19 Sec. 4201.359. NOTICE OF APPEAL. (a) The procedures for
20 appealing an adverse determination must require written notice to
21 the appealing party of the determination of the appeal as soon as
22 practicable, but not later than the 30th calendar day, after the
23 date the utilization review agent receives the appeal.

24 (b) If the appeal is denied, the notice must include a clear
25 and concise statement of:

26 (1) the clinical basis for the denial;

27 (2) the specialty of the physician or other health
28 care provider making the denial; and

29 (3) the appealing party's right to seek review of the
30 denial by an independent review organization under Subchapter I and
31 the procedures for obtaining that review. (V.T.I.C. Art. 21.58A,
32 Sec. 6(b) (part).)

33 Source Law

34 (b) The procedures for appeals . . . must
35 include the following:

36 . . .
37 (6) written notification to the appealing
38 party of the determination of the appeal, as soon as
39 practical, but in no case later than the 30th calendar
40 day after the date the utilization agent receives the
41 appeal. If the appeal is denied, the written
42 notification shall include a clear and concise
43 statement of:

1 (A) the clinical basis for the
2 appeal's denial;
3 (B) the specialty of the physician or
4 other health care provider making the denial; and
5 (C) notice of the appealing party's
6 right to seek review of the denial by an independent
7 review organization under Section 6A of this article
8 and the procedures for obtaining that review.

9 Revisor's Note

10 Section 6(b)(6)(C), V.T.I.C. Article 21.58A,
11 refers to a review by an independent review
12 organization under Section 6A, V.T.I.C. Article
13 21.58A. Section 6A is revised in this chapter in
14 Subchapter I. Although the provision revised as
15 Section 4201.402(b), which is contained in Subchapter
16 I, is not derived from Section 6A, it is appropriate
17 throughout this chapter to substitute references to
18 Subchapter I in its entirety for references to Section
19 6A because the provision revised as Section
20 4201.402(b) applies certain rules and standards to a
21 utilization review agent who provides confidential
22 information to a utilization review organization, and
23 that provision would apply by its own terms in an
24 appeal to an independent review organization conducted
25 under Section 6A.

26 Revised Law

27 Sec. 4201.360. IMMEDIATE APPEAL TO INDEPENDENT REVIEW
28 ORGANIZATION IN LIFE-THREATENING CIRCUMSTANCES. Notwithstanding
29 any other law, in a circumstance involving an enrollee's
30 life-threatening condition, the enrollee is:

31 (1) entitled to an immediate appeal to an independent
32 review organization as provided by Subchapter I; and

33 (2) not required to comply with procedures for an
34 internal review of the utilization review agent's adverse
35 determination. (V.T.I.C. Art. 21.58A, Sec. 6(c).)

36 Source Law

37 (c) Notwithstanding this article or any other
38 law, in a circumstance involving an enrollee's
39 life-threatening condition, the enrollee is entitled

1 to an immediate appeal to an independent review
2 organization as provided by Section 6A of this article
3 and is not required to comply with procedures for an
4 internal review of the utilization review agent's
5 adverse determination.

6 [Sections 4201.361-4201.400 reserved for expansion]

7 SUBCHAPTER I. INDEPENDENT REVIEW OF ADVERSE DETERMINATION

8 Revised Law

9 Sec. 4201.401. REVIEW BY INDEPENDENT REVIEW ORGANIZATION;
10 COMPLIANCE WITH INDEPENDENT DETERMINATION. (a) A utilization
11 review agent shall allow any party whose appeal of an adverse
12 determination is denied by the agent to seek review of that
13 determination by an independent review organization assigned to the
14 appeal in accordance with Chapter 4202.

15 (b) The utilization review agent shall comply with the
16 independent review organization's determination regarding the
17 medical necessity or appropriateness of health care items and
18 services for an enrollee. (V.T.I.C. Art. 21.58A, Sec. 6A (part).)

19 Source Law

20 Sec. 6A. A utilization review agent shall:

21 (1) permit any party whose appeal of an
22 adverse determination is denied by the utilization
23 review agent to seek review of that determination by an
24 independent review organization assigned to the appeal
25 in accordance with Article 21.58C of this code;

26 . . .
27 (3) comply with the independent review
28 organization's determination with respect to the
29 medical necessity or appropriateness of health care
30 items and services for an enrollee; and . . .

31 Revised Law

32 Sec. 4201.402. INFORMATION PROVIDED TO INDEPENDENT REVIEW
33 ORGANIZATION. (a) Not later than the third business day after the
34 date a utilization review agent receives a request for independent
35 review, the agent shall provide to the appropriate independent
36 review organization:

37 (1) a copy of:

38 (A) any medical records of the enrollee that are
39 relevant to the review;

40 (B) any documents used by the plan in making the
41 determination to be reviewed;

1 (C) the written notification described by
2 Section 4201.359; and

3 (D) any documents and other written information
4 submitted to the agent in support of the appeal; and

5 (2) a list of each physician or other health care
6 provider who:

7 (A) has provided care to the enrollee; and

8 (B) may have medical records relevant to the
9 appeal.

10 (b) A utilization review agent may provide confidential
11 information in the custody of the agent to an independent review
12 organization, subject to rules and standards adopted by the
13 commissioner under Chapter 4202. (V.T.I.C. Art. 21.58A, Secs. 6A
14 (part); 8(f), as added Acts 75th Leg., R.S., Ch. 163.)

15 Source Law

16 Sec. 6A. A utilization review agent shall:

17 . . .
18 (2) provide to the appropriate independent
19 review organization not later than the third business
20 day after the date that the utilization review agent
21 receives a request for review a copy of:

22 (A) any medical records of the
23 enrollee that are relevant to the review;

24 (B) any documents used by the plan in
25 making the determination to be reviewed by the
26 organization;

27 (C) the written notification
28 described by Section 6(b)(5) of this article;

29 (D) any documentation and written
30 information submitted to the utilization review agent
31 in support of the appeal; and

32 (E) a list of each physician or
33 health care provider who has provided care to the
34 enrollee and who may have medical records relevant to
35 the appeal;

36 [Sec. 8]

37 (f) Confidential information in the custody of a
38 utilization review agent may be provided to an
39 independent review organization, subject to rules and
40 standards adopted by the commissioner under Article
41 21.58C of this code.

42 Revisor's Note

43 Section 6A(2)(C), V.T.I.C. Article 21.58A,
44 refers to the "written notification described by
45 Section 6(b)(5) of this article." Section 6A, Article
46 21.58A, was enacted by Chapter 163, Acts of the 75th

1 Legislature, Regular Session, 1997. That act also
2 amended Section 6(b)(5), Article 21.58A, in part to
3 reflect an appealing party's right to seek independent
4 review under Section 6A of an adverse utilization
5 review determination. During the same legislative
6 session, the substance of Section 6(b)(5) was amended
7 again and renumbered as Section 6(b)(6) by Chapter
8 1025, Acts of the 75th Legislature, Regular Session,
9 1997. In 1999, Section 6 was amended and reenacted by
10 Chapter 1456, Acts of the 76th Legislature, Regular
11 Session, to reflect the amendments made to that
12 section by Chapters 163 and 1025, Acts of the 75th
13 Legislature, Regular Session, 1997. In that
14 reenactment, the notice provision to which Section
15 6A(2)(C) refers was renumbered as Section 6(b)(6).
16 Thus, the correct citation to the referenced written
17 notice is Section 6(b)(6), revised in this chapter as
18 Section 4201.359, not Section 6(b)(5), revised in this
19 chapter as Section 4201.358. The revised law is
20 drafted accordingly.

21 Revised Law

22 Sec. 4201.403. PAYMENT FOR INDEPENDENT REVIEW. A
23 utilization review agent shall pay for an independent review
24 conducted under this subchapter. (V.T.I.C. Art. 21.58A, Sec. 6A
25 (part).)

26 Source Law

27 Sec. 6A. A utilization review agent shall:

28 . . .
29 (4) pay for the independent review.

30 [Sections 4201.404-4201.450 reserved for expansion]

31 SUBCHAPTER J. SPECIALTY UTILIZATION REVIEW AGENTS

32 Revised Law

33 Sec. 4201.451. DEFINITION. For purposes of this
34 subchapter, "specialty utilization review agent" means a
35 utilization review agent who conducts utilization review for a

1 specialty health care service, including dentistry, chiropractic
2 services, or physical therapy. (V.T.I.C. Art. 21.58A, Sec. 14(j)
3 (part).)

4 Source Law

5 (j) . . . For purposes of this subsection, a
6 specialty utilization review agent means a utilization
7 review agent that conducts utilization review for
8 specialty health care services, including but not
9 limited to dentistry, chiropractic, or physical
10 therapy. . . .

11 Revisor's Note

12 Section 14(j), V.T.I.C. Article 21.58A, refers to
13 "including but not limited to." The revised law omits
14 "but not limited to" for the reason stated in Revisor's
15 Note (5) to Section 4201.002.

16 Revised Law

17 Sec. 4201.452. INAPPLICABILITY OF CERTAIN OTHER LAW. A
18 specialty utilization review agent is not subject to Section
19 4201.151, 4201.152, 4201.206, 4201.252, or 4201.356. (V.T.I.C.
20 Art. 21.58A, Sec. 14(j) (part).)

21 Source Law

22 (j) A specialty utilization review agent is not
23 subject to Section 4(b), (c), (h), or (k) or Section
24 6(b)(3) of this article. . . .

25 Revised Law

26 Sec. 4201.453. UTILIZATION REVIEW PLAN. A specialty
27 utilization review agent's utilization review plan, including
28 reconsideration and appeal requirements, must be reviewed by a
29 health care provider of the appropriate specialty and conducted in
30 accordance with standards developed with input from a health care
31 provider of the appropriate specialty. (V.T.I.C. Art. 21.58A, Sec.
32 14(j) (part).)

33 Source Law

34 (j) . . . A specialty utilization review agent
35 shall comply with the following requirements:

36 (1) the utilization review plan, including
37 reconsideration and appeal requirements, shall be
38 reviewed by a health care provider of the appropriate
39 specialty and conducted in accordance with standards
40 developed with input from a health care provider of the
41 appropriate specialty;

Revised Law

Sec. 4201.454. UTILIZATION REVIEW UNDER DIRECTION OF PROVIDER OF SAME SPECIALTY. A specialty utilization review agent shall conduct utilization review under the direction of a health care provider who is of the same specialty as the agent and who is licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the United States. (V.T.I.C. Art. 21.58A, Sec. 14(j) (part).)

Source Law

(j) . . . A specialty utilization review agent shall comply with the following requirements:

(3) utilization review conducted by a specialty utilization review agent shall be conducted under the direction of a health care provider of the same specialty and shall be licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the United States;

Revised Law

Sec. 4201.455. PERSONNEL. (a) Personnel who are employed by or under contract with a specialty utilization review agent to perform utilization review must be appropriately trained and qualified.

(b) Personnel who obtain oral or written information directly from a physician or other health care provider must be a nurse, physician assistant, or other health care provider of the same specialty as the agent and who are licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the United States.

(c) This section does not require personnel who perform only clerical or administrative tasks to have the qualifications prescribed by this section. (V.T.I.C. Art. 21.58A, Sec. 14(j) (part).)

Source Law

(j) . . . A specialty utilization review agent shall comply with the following requirements:

(2) personnel employed by or under contract with a specialty utilization review agent to perform utilization review shall be appropriately

1 trained and qualified. Personnel who obtain
2 information directly from the physician or health care
3 provider, either orally or in writing, shall be
4 nurses, physician assistants, or other health care
5 providers of the same specialty as the utilization
6 review agent and who are licensed or otherwise
7 authorized to provide the specialty health care
8 service by a state licensing agency in the United
9 States, except that this provision does not require
10 those qualifications for personnel who perform solely
11 clerical or administrative tasks;

12 Revised Law

13 Sec. 4201.456. OPPORTUNITY TO DISCUSS TREATMENT BEFORE
14 ADVERSE DETERMINATION. Subject to the notice requirements of
15 Subchapter G, before a specialty utilization review agent who
16 questions the medical necessity or appropriateness of a health care
17 service issues an adverse determination, the agent shall provide
18 the health care provider who ordered the service a reasonable
19 opportunity to discuss the patient's treatment plan and the
20 clinical basis for the agent's determination with a health care
21 provider who is of the same specialty as the agent. (V.T.I.C. Art.
22 21.58A, Sec. 14(j) (part).)

23 Source Law

24 (j) . . . A specialty utilization review agent
25 shall comply with the following requirements:

26 . . .
27 (4) subject to the notice requirements of
28 Section 5 of this article, in any instance where the
29 specialty utilization review agent questions the
30 medical necessity or appropriateness of health care
31 services, the health care provider who ordered the
32 services shall, prior to the issuance of an adverse
33 determination, be afforded a reasonable opportunity to
34 discuss the plan of treatment for the patient and the
35 clinical basis for the decision of the utilization
36 review agent with a health care provider of the same
37 specialty as the utilization review agent; and

38 Revised Law

39 Sec. 4201.457. APPEAL DECISIONS. A specialty utilization
40 review agent shall comply with the requirement that a physician or
41 other health care provider who makes the decision in an appeal of an
42 adverse determination must be of the same or a similar specialty as
43 the health care provider who would typically manage the specialty
44 condition, procedure, or treatment under review in the appeal.
45 (V.T.I.C. Art. 21.58A, Sec. 14(j) (part).)

Source Law

(j) . . . A specialty utilization review agent shall comply with the following requirements:

(5) appeal decisions shall be made by a physician or health care provider in the same or a similar specialty as typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review of the adverse determination.

Revisor's Note

Section 14(j)(5), V.T.I.C. Article 21.58A, refers to appeal decisions made by health care providers in the "same or a similar specialty as typically manages the medical, dental, or specialty condition, procedure, or treatment." The revised law omits the references to "medical" and "dental" because those terms are included within the meaning of specialty health care services subject to specialty utilization review as described by other provisions of Section 14(j), Article 21.58A, revised in this chapter as Section 4201.451.

[Sections 4201.458-4201.500 reserved for expansion]

SUBCHAPTER K. CLAIMS REVIEW OF MEDICAL NECESSITY AND APPROPRIATENESS

Revised Law

Sec. 4201.501. RETROSPECTIVE REVIEW OF MEDICAL NECESSITY AND APPROPRIATENESS. (a) A retrospective review of the medical necessity and appropriateness of a health care service made under a health insurance policy or health benefit plan shall be based on written screening criteria established and periodically updated with appropriate involvement from physicians, including practicing physicians, and other health care providers.

(b) A payor's system for retrospective review of medical necessity and appropriateness under this section must be under the direction of a physician. (V.T.I.C. Art. 21.58A, Sec. 11(a).)

Source Law

Sec. 11. (a) When a retrospective review of the

1 medical necessity and appropriateness of health care
2 service is made under a health insurance policy or
3 plan: (1) such retrospective review shall be based on
4 written screening criteria established and
5 periodically updated with appropriate involvement
6 from physicians, including practicing physicians, and
7 other health care providers; and (2) the payor's system
8 for such retrospective review of medical necessity and
9 appropriateness shall be under the direction of a
10 physician.

11 Revisor's Note

12 Section 11(a), V.T.I.C. Article 21.58A, refers to
13 a "health insurance policy or plan." The revised law
14 substitutes "health benefit plan" for "plan" for the
15 reason stated in Revisor's Note (7) to Section
16 4201.002.

17 Revised Law

18 Sec. 4201.502. APPEALS OF RETROSPECTIVE ADVERSE
19 DETERMINATIONS. (a) When an adverse determination is made under a
20 health insurance policy or health benefit plan based on a
21 retrospective review of the medical necessity and appropriateness
22 of the allocation of health care resources and services, the payor
23 shall provide the health care provider with the opportunity to
24 appeal the determination in the same manner as provided to the
25 enrollee, with the enrollee's consent to act on the enrollee's
26 behalf. In no event shall a health care provider be precluded from
27 appeal if the enrollee is not reasonably available or competent to
28 consent.

29 (b) The appeal does not imply or confer on a health care
30 provider any contractual right with respect to the enrollee's
31 health insurance policy or health benefit plan that the health care
32 provider does not otherwise have. (V.T.I.C. Art. 21.58A, Sec.
33 11(b).)

34 Source Law

35 (b) When an adverse determination is made under
36 a health insurance policy or plan based on a
37 retrospective review of the medical necessity and
38 appropriateness of the allocation of health care
39 resources and services, the payor shall afford the
40 health care providers the opportunity to appeal the
41 determination in the same manner afforded the
42 enrollee, with the enrollee's consent to act on his or
43 her behalf, but in no event shall health care providers

1 be precluded from appeal if the enrollee is not
2 reasonably available or competent to consent. Such
3 appeal shall not be construed to imply or confer on
4 such health care providers any contract rights with
5 respect to the enrollee's health insurance policy or
6 plan that the health care provider does not otherwise
7 have.

8 Revisor's Note

9 Section 11(b), V.T.I.C. Article 21.58A, refers to
10 a "health insurance policy or plan." The revised law
11 substitutes a reference to a "health insurance policy
12 or health benefit plan" for the reason stated in
13 Revisor's Note (7) to Section 4201.002.

14 [Sections 4201.503-4201.550 reserved for expansion]

15 SUBCHAPTER L. CONFIDENTIALITY OF INFORMATION; ACCESS TO OTHER
16 INFORMATION

17 Revised Law

18 Sec. 4201.551. GENERAL CONFIDENTIALITY REQUIREMENT. (a) A
19 utilization review agent shall preserve the confidentiality of
20 individual medical records to the extent required by law.

21 (b) This chapter does not authorize a utilization review
22 agent to take any action that violates a state or federal law or
23 regulation concerning confidentiality of patient records.
24 (V.T.I.C. Art. 21.58A, Secs. 8(a), (h) (part).)

25 Source Law

26 Sec. 8. (a) A utilization review agent shall
27 preserve the confidentiality of individual medical
28 records to the extent required by law.

29 (h) . . . Nothing in this article shall be
30 construed to allow a utilization review agent to take
31 actions that violate a state or federal statute or
32 regulation concerning confidentiality of patient
33 records.

34 Revised Law

35 Sec. 4201.552. CONSENT REQUIREMENTS. (a) A utilization
36 review agent may not disclose individual medical records, personal
37 information, or other confidential information about a patient
38 obtained in the performance of utilization review without the
39 patient's prior written consent or except as otherwise required by
40 law.

1 (b) If the prior written consent is submitted by anyone
2 other than the patient who is the subject of the personal or
3 confidential information requested, the consent must:

4 (1) be dated; and

5 (2) contain the patient's signature.

6 (c) The patient's signature for purposes of Subsection
7 (b)(2) must have been obtained one year or less before the date the
8 disclosure is sought or the consent is invalid. (V.T.I.C. Art.
9 21.58A, Sec. 8(b).)

10 Source Law

11 (b) A utilization review agent may not disclose
12 or publish individual medical records, personal
13 information, or other confidential information about a
14 patient obtained in the performance of utilization
15 review without the prior written consent of the
16 patient or as otherwise required by law. If such
17 authorization is submitted by anyone other than the
18 individual who is the subject of the personal or
19 confidential information requested, such
20 authorization must:

21 (1) be dated; and

22 (2) contain the signature of the
23 individual who is the subject of the personal or
24 confidential information requested. The signature
25 must have been obtained one year or less prior to the
26 date the disclosure is sought or the authorization is
27 invalid.

28 Revisor's Note

29 Section 8(b), V.T.I.C. Article 21.58A, provides
30 that a utilization review agent may not "disclose or
31 publish" certain information. The revised law omits
32 the reference to "publish" because, in this context,
33 "publish" is included in the meaning of "disclose."

34 Revised Law

35 Sec. 4201.553. PROVIDING INFORMATION TO AFFILIATED
36 ENTITIES. A utilization review agent may provide confidential
37 information to a third party under contract with or affiliated with
38 the agent solely to perform or assist with utilization review.
39 Information provided to a third party under this section remains
40 confidential. (V.T.I.C. Art. 21.58A, Sec. 8(c).)

41 Source Law

42 (c) A utilization review agent may provide

1 confidential information to a third party under
2 contract or affiliated with the utilization review
3 agent for the sole purpose of performing or assisting
4 with utilization review. Information provided to
5 third parties shall remain confidential.

6 Revised Law

7 Sec. 4201.554. PROVIDING INFORMATION TO COMMISSIONER.
8 Notwithstanding this subchapter, a utilization review agent shall
9 provide to the commissioner on request individual medical records
10 or other confidential information to enable the commissioner to
11 determine compliance with this chapter. The information is
12 confidential and privileged and is not subject to Chapter 552,
13 Government Code, or to subpoena, except to the extent necessary to
14 enable the commissioner to enforce this chapter. (V.T.I.C. Art.
15 21.58A, Sec. 8(i).)

16 Source Law

17 (i) Notwithstanding the provisions in
18 Subsections (a) through (h) of this section, the
19 utilization review agent shall provide to the
20 commissioner on request individual medical records or
21 other confidential information for determination of
22 compliance with this article. The information is
23 confidential and privileged and is not subject to the
24 open records law, Chapter 552, Government Code, or to
25 subpoena, except to the extent necessary to enable the
26 commissioner to enforce this article.

27 Revisor's Note

28 Section 8(i), V.T.I.C. Article 21.58A, provides
29 that, "[n]otwithstanding the provisions in
30 Subsections (a) through (h)" of Section 8, a
31 utilization review agent shall provide certain
32 confidential information to the commissioner of
33 insurance. The referenced provisions are revised as
34 Subchapter L of this chapter, which includes this
35 section, with the exception of Section 8(f), as added
36 by Chapter 163, Acts of the 75th Legislature, Regular
37 Session, 1997. That section is revised in Subchapter I
38 of this chapter as Section 4201.402(b). The revised
39 law substitutes "[n]otwithstanding this subchapter"
40 for the quoted language and does not include a
41 reference to Section 4201.402(b) because that

1 provision does not restrict or otherwise relate to a
2 utilization review agent providing information to the
3 commissioner.

4 Revised Law

5 Sec. 4201.555. ACCESS TO RECORDED PERSONAL INFORMATION.

6 (a) If an individual submits a written request to a utilization
7 review agent for access to recorded personal information concerning
8 the individual, the agent shall, within 10 business days from the
9 date the agent receives the request:

10 (1) inform the requesting individual in writing of the
11 nature and substance of the recorded personal information; and

12 (2) allow the individual, at the individual's
13 discretion, to:

14 (A) view and copy, in person, the recorded
15 personal information concerning the individual; or

16 (B) obtain a copy of the information by mail.

17 (b) If the information requested under this section is in
18 coded form, the utilization review agent shall provide in writing
19 an accurate translation of the information in plain language.

20 (c) A utilization review agent's charges for providing a
21 copy of information requested under this section shall be
22 reasonable, as determined by rule adopted by the commissioner. The
23 charges may not include any costs otherwise recouped as part of the
24 charges for utilization review. (V.T.I.C. Art. 21.58A, Secs. 8(d),
25 (e).)

26 Source Law

27 (d) If an individual submits a written request
28 to the utilization review agent for access to recorded
29 personal information about the individual, the
30 utilization review agent shall within 10 business days
31 from the date such request is received:

32 (1) inform the individual submitting the
33 request of the nature and substance of the recorded
34 personal information in writing; and

35 (2) permit the individual to see and copy,
36 in person, the recorded personal information
37 pertaining to the individual or to obtain a copy of the
38 recorded personal information by mail, at the
39 discretion of the individual, unless the recorded
40 personal information is in coded form, in which case an
41 accurate translation in plain language shall be

1 provided in writing.

2 (e) A utilization review agent's charges for
3 providing a copy of recorded personal information to
4 individuals shall be reasonable, as determined by rule
5 of the commissioner, and may not include any costs that
6 are otherwise recouped as part of the charge for
7 utilization review.

8 Revised Law

9 Sec. 4201.556. PUBLISHING INFORMATION IDENTIFIABLE TO
10 HEALTH CARE PROVIDER. (a) A utilization review agent may not
11 publish data that identifies a particular physician or other health
12 care provider, including data in a quality review study or
13 performance tracking data, without providing prior written notice
14 to the physician or other provider.

15 (b) The prohibition under this section does not apply to
16 internal systems or reports used by the utilization review agent.
17 (V.T.I.C. Art. 21.58A, Sec. 8(f), as added Acts 75th Leg., R.S., Ch.
18 1025.)

19 Source Law

20 (f) The utilization review agent may not publish
21 data which identifies a particular physician or health
22 care provider, including any quality review studies or
23 performance tracking data, without prior written
24 notice to the involved provider. This prohibition
25 does not apply to internal systems or reports used by
26 the utilization review agent.

27 Revised Law

28 Sec. 4201.557. REQUIREMENT TO MAINTAIN DATA IN CONFIDENTIAL
29 MANNER. A utilization review agent shall maintain all data
30 concerning a patient or physician or other health care provider in a
31 confidential manner that prevents unauthorized disclosure to a
32 third party. (V.T.I.C. Art. 21.58A, Sec. 8(h) (part).)

33 Source Law

34 (h) All patient, physician, and health care
35 provider data shall be maintained by the utilization
36 review agent in a confidential manner which prevents
37 unauthorized disclosure to third parties. . . .

38 Revised Law

39 Sec. 4201.558. DESTRUCTION OF CERTAIN CONFIDENTIAL
40 DOCUMENTS. When a utilization review agent determines a document
41 in the custody of the agent that contains confidential patient
42 information or confidential physician or other health care provider

1 financial data is no longer needed, the document shall be destroyed
2 by a method that ensures the complete destruction of the
3 information. (V.T.I.C. Art. 21.58A, Sec. 8(g).)

4 Source Law

5 (g) Documents in the custody of the utilization
6 review agent that contain confidential patient
7 information or physician or health care provider
8 financial data shall be destroyed by a method which
9 induces complete destruction of the information when
10 the agent determines the information is no longer
11 needed.

12 [Sections 4201.559-4201.600 reserved for expansion]

13 SUBCHAPTER M. ENFORCEMENT

14 Revised Law

15 Sec. 4201.601. NOTICE OF SUSPECTED VIOLATION; COMPELLING
16 PRODUCTION OF INFORMATION. If the commissioner believes that a
17 person or entity conducting utilization review is in violation of
18 this chapter or applicable rules, the commissioner:

19 (1) shall notify the utilization review agent, health
20 maintenance organization, or insurer of the alleged violation; and

21 (2) may compel the production of documents or other
22 information as necessary to determine whether a violation has
23 occurred. (V.T.I.C. Art. 21.58A, Sec. 9(a).)

24 Source Law

25 Sec. 9. (a) If the commissioner believes that
26 any person or entity conducting utilization review
27 pursuant to this article is in violation of this
28 article or applicable regulations, the commissioner
29 shall notify the utilization review agent, health
30 maintenance organization, or insurer of the alleged
31 violation and may compel the production of any and all
32 documents or other information as necessary in order
33 to determine whether or not such violation has taken
34 place.

35 Revisor's Note

36 Section 9(a), V.T.I.C. Article 21.58A, refers to
37 "regulations" concerning utilization review. The
38 revised law substitutes "rules" for "regulations" for
39 the reason stated in Revisor's Note (3) to Section
40 4201.003.

Revised Law

Sec. 4201.602. ENFORCEMENT PROCEEDING. (a) The commissioner may initiate a proceeding under this subchapter.

(b) A proceeding under this chapter is a contested case for purposes of Chapter 2001, Government Code. (V.T.I.C. Art. 21.58A, Secs. 9(b), (c).)

Source Law

(b) The commissioner may initiate the proceedings under this section.

(c) Proceedings under this article are a contested case for the purposes of the administrative procedure act.

Revised Law

Sec. 4201.603. REMEDIES AND PENALTIES FOR VIOLATION. If the commissioner determines that a utilization review agent, health maintenance organization, insurer, or other person or entity conducting utilization review has violated or is violating this chapter, the commissioner may:

- (1) impose a sanction under Chapter 82;
- (2) issue a cease and desist order under Chapter 83;
- (3) assess an administrative penalty under Chapter 84.

(V.T.I.C. Art. 21.58A, Sec. 9(d).)

Source Law

(d) If the commissioner determines that the utilization review agent, health maintenance organization, insurer, or other person or entity conducting utilization review pursuant to this article has violated or is violating any provision of this article, the commissioner may:

- (1) impose sanctions under Section 7, Article 1.10 of this code;
- (2) issue a cease and desist order under Article 1.10A of this code; or
- (3) assess administrative penalties under Article 1.10E of this code.

CHAPTER 4202. INDEPENDENT REVIEW ORGANIZATIONS

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12 CHAPTER 4202. INDEPENDENT REVIEW ORGANIZATIONS

13 Revised Law

14 Sec. 4202.001. DEFINITION. In this chapter, "payor" has
15 the meaning assigned by Section 4201.002. (V.T.I.C. Art. 21.58C,
16 Sec. 1(2).)

17 Source Law

18 (2) "Payor" has the meaning assigned by
19 Section 2, Article 21.58A of this code.

20 Revised Law

21 Sec. 4202.002. ADOPTION OF STANDARDS FOR INDEPENDENT REVIEW
22 ORGANIZATIONS. (a) The commissioner shall adopt standards and
23 rules for:

24 (1) the certification, selection, and operation of
25 independent review organizations to perform independent review
26 described by Subchapter I, Chapter 4201; and

27 (2) the suspension and revocation of the
28 certification.

29 (b) The standards adopted under this section must ensure:

30 (1) the timely response of an independent review
31 organization selected under this chapter;

32 (2) the confidentiality of medical records
33 transmitted to an independent review organization for use in
34 conducting an independent review;

1 (3) the qualifications and independence of each
2 physician or other health care provider making a review
3 determination for an independent review organization;

4 (4) the fairness of the procedures used by an
5 independent review organization in making review determinations;
6 and

7 (5) the timely notice to an enrollee of the results of
8 an independent review, including the clinical basis for the review
9 determination. (V.T.I.C. Art. 21.58C, Secs. 2(a) (part), (b).)

10 Source Law

11 Sec. 2. (a) The commissioner shall:

12 (1) promulgate standards and rules for:

13 (A) the certification, selection,
14 and operation of independent review organizations to
15 perform independent review described by Section 6,
16 Article 21.58A of this code; and

17 (B) the suspension and revocation of
18 the certification;

19

20 (b) The standards required by Subsection (a)(1)
21 of this section must ensure:

22 (1) the timely response of an independent
23 review organization selected under this article;

24 (2) the confidentiality of medical records
25 transmitted to an independent review organization for
26 use in independent reviews;

27 (3) the qualifications and independence of
28 each health care provider or physician making review
29 determinations for an independent review
30 organization;

31 (4) the fairness of the procedures used by
32 an independent review organization in making the
33 determinations; and

34 (5) timely notice to enrollees of the
35 results of the independent review, including the
36 clinical basis for the determination.

37 Revisor's Note

38 Section 2(a)(1)(A), V.T.I.C. Article 21.58C,
39 refers to independent review organizations that
40 perform "independent review described by Section 6,
41 Article 21.58A of this code." The reference to Section
42 6, V.T.I.C. Article 21.58A, appears to be a
43 typographical error. Section 6, Article 21.58A,
44 revised as Subchapter H, Chapter 4201, of this code,
45 provides procedures for appealing an adverse
46 determination made by a utilization review agent. The

1 review of an appeal under Section 6 is conducted by a
2 physician or other health care provider under the
3 direction of the utilization review agent. If the
4 appeal of the adverse determination is denied under
5 Section 6, the party whose appeal was denied may appeal
6 to an independent review organization under Section
7 6A, V.T.I.C. Article 21.58A, revised as Subchapter I,
8 Chapter 4201, of this code. It is clear from the
9 context that the legislature intended to refer to
10 independent review conducted by an independent review
11 organization as provided by Section 6A. For that
12 reason, the revised law substitutes a reference to
13 Subchapter I, Chapter 4201, of this code.

14 Although the provision revised as Section
15 4201.402(b), which is contained in Subchapter I,
16 Chapter 4201, is not derived from Section 6A, it is
17 appropriate throughout this chapter to substitute
18 references to Subchapter I in its entirety for
19 references to Section 6A because the provision revised
20 as Section 4201.402(b) applies certain rules and
21 standards to a utilization review agent who provides
22 confidential information to a utilization review
23 organization, and that provision would apply by its
24 own terms in an appeal to an independent review
25 organization conducted under Section 6A.

26 Revised Law

27 Sec. 4202.003. REQUIREMENTS REGARDING TIMELINESS OF
28 DETERMINATION. The standards adopted under Section 4202.002 must
29 require each independent review organization to make the
30 organization's determination:

31 (1) for a life-threatening condition as defined by
32 Section 4201.002, not later than the earlier of:

33 (A) the fifth day after the date the organization
34 receives the information necessary to make the determination; or

1 (B) the eighth day after the date the
2 organization receives the request that the determination be made;
3 and

4 (2) for a condition other than a life-threatening
5 condition, not later than the earlier of:

6 (A) the 15th day after the date the organization
7 receives the information necessary to make the determination; or

8 (B) the 20th day after the date the organization
9 receives the request that the determination be made. (V.T.I.C.
10 Art. 21.58C, Secs. 1(1), 2(c).)

11 Source Law

12 Art. 21.58C

13 Sec. 1. In this article:

14 (1) "Life-threatening condition" has the
15 meaning assigned by Section 6, Article 21.58A of this
16 code.

17 [Sec. 2]

18 (c) The standards adopted under Subsection
19 (a)(1) of this section must include standards that
20 require each independent review organization to make
21 its determination:

22 (1) not later than the earlier of:

23 (A) the 15th day after the date the
24 independent review organization receives the
25 information necessary to make the determination; or

26 (B) the 20th day after the date the
27 independent review organization receives the request
28 that the determination be made; and

29 (2) in the case of a life-threatening
30 condition, not later than the earlier of:

31 (A) the fifth day after the date the
32 independent review organization receives the
33 information necessary to make the determination; or

34 (B) the eighth day after the date the
35 independent review organization receives the request
36 that the determination be made.

37 Revisor's Note

38 Section 1(1), V.T.I.C. Article 21.58C, defines
39 "life-threatening condition" to have the meaning
40 assigned by Section 6, V.T.I.C. Article 21.58A.
41 Section 6(c) of that article, as originally enacted by
42 Chapter 163, Acts of the 75th Legislature, Regular
43 Session, 1997, defined "life-threatening condition"
44 for purposes of Section 6. During the same legislative
45 session, the legislature enacted Chapter 1025, Acts of

1 the 75th Legislature, Regular Session, 1997, which
2 added a definition of "life threatening" as Section
3 2(12), V.T.I.C. Article 21.58A, revised in Section
4 4201.002 of this code. That definition was
5 substantively identical to the definition enacted in
6 Section 6(c) and applied to the entire article, making
7 the definition in Section 6(c) superfluous. The
8 legislature subsequently enacted Chapter 1456, Acts of
9 the 76th Legislature, Regular Session, 1999, which
10 repealed the definition contained in Section 6(c).
11 For that reason, the revised law substitutes a
12 reference to Section 4201.002 of this code for the
13 reference to Section 6, Article 21.58A.

14 In addition, the definition of "life-threatening
15 condition" provided by Section 1(1), Article 21.58C,
16 applies to the entire article, revised as this
17 chapter. The revised law incorporates the substance
18 of the definition in this section because the term only
19 appears in Section 2(c), Article 21.58C, which is
20 revised in this section.

21 Revised Law

22 Sec. 4202.004. CERTIFICATION. To be certified as an
23 independent review organization under this chapter, an
24 organization must submit to the commissioner an application in the
25 form required by the commissioner. The application must include:

26 (1) for an applicant that is publicly held, the name of
27 each shareholder or owner of more than five percent of any of the
28 applicant's stock or options;

29 (2) the name of any holder of the applicant's bonds or
30 notes that exceed \$100,000;

31 (3) the name and type of business of each corporation
32 or other organization that the applicant controls or is affiliated
33 with and the nature and extent of the control or affiliation;

34 (4) the name and a biographical sketch of each

1 director, officer, and executive of the applicant and of any entity
2 listed under Subdivision (3) and a description of any relationship
3 the named individual has with:

4 (A) a health benefit plan;

5 (B) a health maintenance organization;

6 (C) an insurer;

7 (D) a utilization review agent;

8 (E) a nonprofit health corporation;

9 (F) a payor;

10 (G) a health care provider; or

11 (H) a group representing any of the entities
12 described by Paragraphs (A) through (G);

13 (5) the percentage of the applicant's revenues that
14 are anticipated to be derived from independent reviews conducted
15 under Subchapter I, Chapter 4201;

16 (6) a description of the areas of expertise of the
17 physicians or other health care providers making review
18 determinations for the applicant; and

19 (7) the procedures to be used by the applicant in
20 making independent review determinations under Subchapter I,
21 Chapter 4201. (V.T.I.C. Art. 21.58C, Sec. 2(d).)

22 Source Law

23 (d) To be certified as an independent review
24 organization under this article, an organization must
25 submit to the commissioner an application in the form
26 required by the commissioner. The application must
27 include:

28 (1) for an applicant that is publicly
29 held, the name of each stockholder or owner of more
30 than five percent of any stock or options;

31 (2) the name of any holder of bonds or
32 notes of the applicant that exceed \$100,000;

33 (3) the name and type of business of each
34 corporation or other organization that the applicant
35 controls or is affiliated with and the nature and
36 extent of the affiliation or control;

37 (4) the name and a biographical sketch of
38 each director, officer, and executive of the applicant
39 and any entity listed under Subdivision (3) of this
40 subsection and a description of any relationship the
41 named individual has with:

42 (A) a health benefit plan;

43 (B) a health maintenance
44 organization;

45 (C) an insurer;

(D) a utilization review agent;
(E) a nonprofit health corporation;
(F) a payor;
(G) a health care provider; or
(H) a group representing any of the
entities described by Paragraphs (A) through (G) of
this subdivision;

(5) the percentage of the applicant's
revenues that are anticipated to be derived from
reviews conducted under Section 6A, Article 21.58A of
this code;

(6) a description of the areas of
expertise of the health care professionals making
review determinations for the applicant; and

(7) the procedures to be used by the
independent review organization in making review
determinations with respect to reviews conducted under
Section 6A, Article 21.58A of this code.

Revisor's Note

Section 2(d)(6), V.T.I.C. Article 21.58C, refers
to "health care professionals" who make review
determinations. The standards the commissioner of
insurance is required to adopt under Section 2(b)(3),
V.T.I.C. Article 21.58C, revised as Section
4202.002(b)(3), refer to a "health care provider or
physician" making those determinations. The revised
law substitutes "physicians or other health care
providers" for "health care professionals" for
consistency of terminology throughout this chapter.

Revised Law

Sec. 4202.005. PERIODIC REPORTING OF INFORMATION; ANNUAL
DESIGNATION. (a) An independent review organization shall
annually submit the information required in an application for
certification under Section 4202.004. Anytime there is a material
change in the information the organization included in the
application, the organization shall submit updated information to
the commissioner.

(b) The commissioner shall designate annually each
organization that meets the standards for an independent review
organization adopted under Section 4202.002. (V.T.I.C. Art.
21.58C, Secs. 2(a) (part), (e).)

Source Law

(a) The commissioner shall:

1 . . .
2 (2) designate annually each organization
3 that meets the standards as an independent review
4 organization;
5

6 (e) The independent review organization shall
7 annually submit the information required by Subsection
8 (d) of this section. If at any time there is a material
9 change in the information included in the application
10 under Subsection (d) of this section, the independent
11 review organization shall submit updated information
12 to the commissioner.

13 Revised Law

14 Sec. 4202.006. PAYORS FEES. The commissioner shall charge
15 payors fees in accordance with this chapter as necessary to fund the
16 operations of independent review organizations. (V.T.I.C.
17 Art. 21.58C, Sec. 2(a) (part).)

18 Source Law

19 (a) The commissioner shall:
20 . . .
21 (3) charge payors fees in accordance with
22 this article as necessary to fund the operations of
23 independent review organizations; and
24

25 Revised Law

26 Sec. 4202.007. OVERSIGHT. The commissioner shall provide
27 ongoing oversight of the independent review organizations to ensure
28 continued compliance with this chapter and the standards and rules
29 adopted under this chapter. (V.T.I.C. Art. 21.58C, Sec. 2(a)
30 (part).)

31 Source Law

32 (a) The commissioner shall:
33 . . .
34 (4) provide ongoing oversight of the
35 independent review organizations to ensure continued
36 compliance with this article and the standards and
37 rules adopted under this article.

38 Revised Law

39 Sec. 4202.008. PROHIBITED OWNERSHIP OR CONTROL OF
40 INDEPENDENT REVIEW ORGANIZATION. An independent review
41 organization may not be a subsidiary of, or in any way owned or
42 controlled by, a payor or a trade or professional association of
43 payors. (V.T.I.C. Art. 21.58C, Sec. 2(f).)

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Source Law

(f) An independent review organization may not be a subsidiary of, or in any way owned or controlled by, a payor or a trade or professional association of payors.

Revised Law

Sec. 4202.009. CONFIDENTIAL INFORMATION. Information that reveals the identity of a physician or other individual health care provider who makes a review determination for an independent review organization is confidential. (V.T.I.C. Art. 21.58C, Sec. 2(h).)

Source Law

(h) Information that reveals the identity of a physician or individual health care provider who makes a review determination for an independent review organization is confidential.

Revised Law

Sec. 4202.010. IMMUNITY FROM LIABILITY. (a) An independent review organization conducting an independent review under Subchapter I, Chapter 4201, is not liable for damages arising from the review determination made by the organization.

(b) This section does not apply to an act or omission of the independent review organization that is made in bad faith or that involves gross negligence. (V.T.I.C. Art. 21.58C, Sec. 2(g).)

Source Law

(g) An independent review organization conducting a review under Section 6A, Article 21.58A of this code is not liable for damages arising from the determination made by the organization. This subsection does not apply to an act or omission of the independent review organization that is made in bad faith or that involves gross negligence.

CHAPTER 4203. PROHIBITED CONSULTANT ACTIVITIES

Sec. 4203.001. DEFINITION 1726

Sec. 4203.002. PROHIBITED CONSULTANT ACTIVITIES 1727

CHAPTER 4203. PROHIBITED CONSULTANT ACTIVITIES

Revised Law

Sec. 4203.001. DEFINITION. In this chapter, "consultant" means a person who, for compensation and at the request of an insurer, business, individual, or utilization review agent:

- (1) reviews, assesses, or evaluates a claim, charge,

1 or service of another chiropractor to determine whether the claim,
2 charge, or service is:

3 (A) medically necessary, reasonable, or
4 appropriate; or

5 (B) recommended for payment or nonpayment; or

6 (2) advises an insurer or utilization review agent
7 regarding a chiropractic charge or service or recommends to that
8 insurer or agent guidelines for a chiropractic charge or service.
9 (V.T.I.C. Art. 21.58B (part).)

10 Source Law

11 . . . For the purposes of this section, the term
12 "consultant" means a person who: (1) for compensation
13 and at the request of an insurance company, business,
14 individual or utilization review agent, reviews,
15 assesses or evaluates any claim, charge, treatment or
16 service of another chiropractor for the purposes of
17 determining if said claims, charges, treatment or
18 services are medically necessary, reasonable,
19 appropriate or are recommended for payment or
20 non-payment; or (2) for compensation and at the
21 request of an insurance company, business, individual
22 or utilization review agent, advises or recommends to
23 any insurance company or utilization review agent,
24 guidelines regarding chiropractic charges, treatment
25 or services.

26 Revisor's Note

27 V.T.I.C. Article 21.58B refers to any "treatment
28 or service" of a chiropractor and to chiropractic
29 "treatment or services." The revised law omits as
30 unnecessary the reference to "treatment" because in
31 this context, "treatment" is included within the
32 meaning of "service."

33 Revised Law

34 Sec. 4203.002. PROHIBITED CONSULTANT ACTIVITIES. A member
35 or employee of the Texas Board of Chiropractic Examiners may not act
36 as a consultant or perform any consultant activities for an insurer
37 or business, individual, or utilization review agent that audits
38 chiropractic claims, charges, or services. (V.T.I.C. Art. 21.58B
39 (part).)

40 Source Law

41 Art. 21.58B. A member or employee of the Board

1 of Chiropractic Examiners shall be prohibited from
2 acting as a consultant or performing any consultant
3 activities for any insurance company or business,
4 individual or utilization review agent that audits
5 chiropractic claims, charges or services. . . .

6 Revisor's Note

7 V.T.I.C. Article 21.58B refers to the "Board of
8 Chiropractic Examiners." The revised law substitutes
9 "Texas Board of Chiropractic Examiners" because under
10 Chapter 201, Occupations Code, that is the correct
11 name of the board.